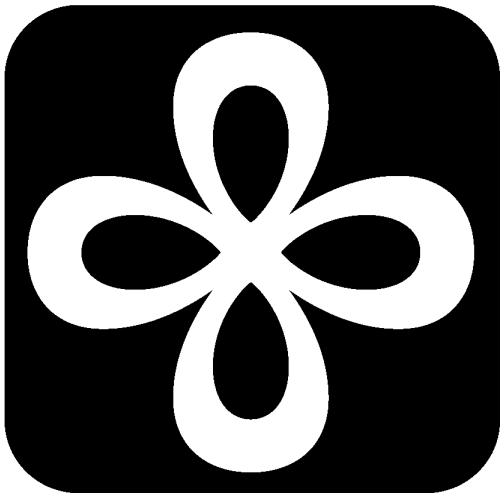
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

HCBS AIDS/HIV Waiver Services

CHAPTER E: COVERAGE AND LIMITATIONS

Page

APPENDIX Page

I. THE AIDS/HIV WAIVER

The HCBS AIDS/HIV waiver program offers services to persons with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection. Waiver services maintain Medicaid-eligible people in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective and necessary to prevent institutionalization.

The waiver program offers specific services beyond what are available through the regular Medicaid program. This means that home health aide, nursing, and counseling services, which are available through regular Medicaid, must be used through the regular Medicaid program before they are used through the waiver.

Eligible children should access Care for Kids (EPSDT) for home health aide or nursing services beyond intermittent. Consumers aged 21 or over may access HCBS services to receive needed home health aide or nursing services beyond the intermittent services covered under regular Medicaid.

The services offered under the HCBS AIDS/HIV waiver program are:

- Adult day care.
- Consumer-directed attendant care.
- Counseling.
- Home-delivered meals.
- Home health aide.
- Homemaker.
- Nursing.
- Respite.

Waiver services are payable only when:

- A Department of Human Services income maintenance worker has determined that the consumer meets Medicaid criteria for income, resources, and level of care. People diagnosed with AIDS or HIV who require the level of care otherwise provided in a nursing facility or hospital can be determined eligible.

  The Medicaid groups eligible to receive AIDS/HIV waiver services include:

  - People eligible under Supplemental Security Income (SSI), SSI-related, Family Medical Assistance Program (FMAP), or FMAP-related coverage groups.
  - Medically needy eligibles who require hospital level of care.
  - People eligible under a special income level (whose income exceeds the SSI limit but does not exceed 300% of the maximum monthly SSI payment for one person).
  - People in the community who become eligible through application of the institutional deeming rules (people who would otherwise be Medicaid eligible only if institutionalized because income and resources from a parent or spouse are not deemed available to the person then).

- A Department of Human Services service worker has determined service eligibility and has developed a service plan for the consumer, and the service plan is made available to the provider.

  - The Department service worker assesses the person's need for waiver services and determines the availability and appropriateness of services. This assessment is based, in part, on information in the completed form 470-0659, *Home- and Community-Based Services Assessment or Reassessment*. Form 470-0659 is completed annually.
  - Individual service costs which make up the monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1,650 unless a waiver of this limit is granted by the Bureau of Long-Term Care, upon request by the Department service worker.
  - Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services.

- The consumer must require and use one service available under the waiver at least quarterly.
- The service worker prepares a service plan for the consumer every 12 months or when there is significant change in the person's situation or condition. The service plan must include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

A. Provider Enrollment

To apply for certification as a waiver service provider, contact the fiscal agent for the Bureau of Long-Term Care by phone at 800-338-7909 or in writing at:

ACS
Provider Relations
PO Box 14422
Des Moines, IA 50306-3422

You will receive an application packet containing:

- Form 470-2917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion,
- Form 470-2965, *Agreement Between Provider of Medical and Health Services and Iowa Department of Human Services re Participation in Medical Assistance Program*, and
- Form W-9, *Request for Taxpayer Identification Number and Certification.*

Submit the completed application to the **same office**. The fiscal agent must receive your application for certification at least 90 days before your planned implementation date.

HCBS specialists review the submitted application. They will contact you if they require additional information or clarification. This may include:

- Your current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.
- Your fiscal capacity to initiate and operate the specified programs on an ongoing basis.
- Your written agreement to work cooperatively with the state and the central point of coordination in the counties you will serve.

HCBS specialists have 60 days from the receipt of your application to determine whether you meet the applicable standards for providing waiver services. (This deadline may be extended by mutual consent.)

When your application is approved, HCBS specialists will recommend enrollment. ACS will provide verification of approval of services, the provider manual and claim forms.

Review of a provider may occur at any time that it is determined to be necessary.

B. Facsimile of Form 470-2917

See the following pages for a facsimile of form 470-2917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion.

INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID HCBS WAIVER PROVIDER APPLICATION FORM

I. GENERAL SECTION

1-7 Enter the current provider number, name, and the address of the provider of service. If the billing address is different than the street address, attach the "pay to" address to the form.

8-9 **County Name and Number**. Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).

10 **Phone**. Enter area code and phone number.

11 **Fax**. Enter area code and fax number, if available.

12 **E-mail address**. Enter email address, if available. By providing us with your email address, you agree that we may communicate with you by electronic mail.

13 **Desired Effective Date for Enrollment**. Cannot be retroactive before the first of the month in which the application was signed. Providers cannot bill or be paid for service provided prior to DHS agreement to the service.

14 **HCBS Waiver**. Indicate the HCBS waiver program(s) for which application is being made.

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

If you are applying on behalf of an agency, proceed to section III.

If you are an individual applying for services other than Consumer-Directed Attendant Care, proceed to Section III (**this is not common!**).

15 **Social Security Number**. Enter your social security number here.

16 Indicate that you are applying for Consumer-Directed Attendant Care. Indicate whether you are going to provide the service on the daily or hourly basis (or both).

- Individuals who apply to provide Consumer-Directed Attendant Care are required to submit proof of age and must send in a copy of either a birth certificate **OR** a driver's license. The date of birth must be clearly visible or it will not be accepted.

- All of the forms must be completed. Individuals must fill out the W-9 form. All taxes on income earned from providing CDAC services are the responsibility of the individual providing the service.

Note: The CDAC provider cannot bill or be paid for service provided prior to Department of Human Service written approval of this service. That is indicated by the DHS service worker attaching the HCBS Consumer Directed Attendant Care Agreement, form 470-3372, to the service plan in the Ill and Handicapped, AIDS/HIV, and Elderly and Physical Disability waivers. In the Brain Injury and Mental Retardation waivers, the CDAC Agreement is attached to the service plan and sign off is obtained by sending a form 470-0379 to the Division of Long Term Care in DHS central office. Any payments made prior to the DHS written approval of this service are fraud, and referrals for recovery and prosecution of this federal offense will be made.

17 **Signature**. Original signature required. Applications not properly signed will be returned.

18 **Date**. Enter date application is signed.

III. AGENCIES APPLYING FOR WAIVER SERVICES

15 **Tax ID Number**. Enter your IRS Tax ID number.

16 **Contact Person**. Enter the name of the person who should be contacted for questions in regards to the application.

17-21 Self-explanatory.

22 **Claims in Process Information**. Paid and denied claims will automatically be reported to you. You have three choices regarding suspended claims, i.e. claims currently in process pending resolution of one or more issues. Those choices are:

Y = Print suspended claims only once. You will be notified only once that we have received your claim and that it is in process. You will not be notified about the claim again until it either pays or denies.

A = Print all suspended claims until paid or denied. You will be notified every week about all claims that are in process.

N = Do not print suspended claims. You will receive no notice concerning claims in process until they either pay or deny.

23 **Remittance Sequence**. Choose which sequence your claims will be reported to you. The choices are:

By Recipient Name. Claims will be reported in alphabetic order by recipient's last name.

By Recipient ID. Claims will be reported in numeric order by recipient's Medicaid ID number.

24 Indicate which services under which waivers you are applying for, and which standards you meet. Include with the application the documentation that the specific requirement is met.

25 **Signature**. Original signature required. Applications not properly signed will be returned.

26 **Date**. Enter date application is signed.

Iowa Department of Human Services

Medicaid HCBS Waiver Provider Application

When completed send to:	**Make sure you have read the instructions before completing this form!**	For questions, contact:
ACS, Inc. Provider Enrollment P.O. Box 14422 Des Moines, IA 50306-3422 **Tel. (800) 338-7909**		HCBS Waiver Program Tel: **(515) 281-8061** email: **akryuch@dhs.state.ia.us**

Individual applicants applying for Consumer-Directed Attendant Care (CDAC), please, complete sections I and II.
Agencies applying for services, please, complete sections I and III.

I. GENERAL SECTION

1. Current Provider Number (if already an HCBS provider)	**0**
2. Provider Name	
3. Street Address	**4. Suite or Apt. #**
5. City	**6. State**
7. Zip Code (9-digit if known)	**–**
8. County Name	**9. County Number**
10. Telephone Number	**( )** **–**
11. Fax Number	**( )** **–**
12. E-mail Address (please, print)	
13. Desired Effective Date for Enrollment (MM/DD/YYYY) **(THIS DATE CANNOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS SIGNED!)**	**/** **/**

14. Indicate the HCBS waiver program(s) for which application is being made

- ❑ Ill & Handicapped (IH)
- ❑ AIDS/HIV (AH)
- ❑ Elderly (E)
- ❑ Mentally Retarded (MR)
- ❑ Brain Injury (BI)*
- ❑ Physical Disability (PD)

***** – Those wishing to provide services under the Brain Injury waiver need to submit documentation indicating training or experience with persons with brain injury. Training classes are available through DHS. To receive training call (515) 281-8061.

If you are an individual applicant applying for Consumer-Directed Attendant Care (CDAC), please, proceed to section II. Otherwise, proceed to section III.

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

15. Social Security Number				–			–				

16. Indicate that you are applying for Consumer-Directed Attendant Care (CDAC)

Service and Requirements	Circle the waiver(s) for which you are applying
❑ 04 – Consumer Directed Attendant Care (CDAC)	
❑ 21 – Individual Applicant must submit a photocopy of birth certificate **OR** driver's license. Must show date of birth. →	IH AH E MR BI PD

Read and sign the following statement:

As a Medicaid provider of consumer-directed attendant care services:

- I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.
- I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.
- I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.
- I understand that I must describe in detail my training and/or experience on form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and this will be reviewed and approved by the case manager or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.
- I hereby confirm that all information provided by me on this form is true and correct to my best knowledge.

17. Signature

18. Date			/			/				

Note: Once the application process has been completed, you will receive notification from ACS.

III. AGENCIES APPLYING FOR WAIVER SERVICES

15. Tax ID Number			–							

16. Contact Person ❑ Mr ❑ Ms

17. Do you have any HCBS waiver-related provider numbers besides the one shown in question 1? If "yes", please, list them here ❑ Yes ❑ No

18. Has there been any disciplinary action against you by any licensing boards or certification body? ❑ Yes ❑ No

19. Have you ever been excluded from participation in the Medicare Program? If "yes," please explain on a separate piece of paper ❑ Yes ❑ No

20. Type of Practice Code (Please Check One)

❑ 01 – Individual Applicant	❑ 05 – Government Owned	❑ 09 – Group
❑ 02 – Partnership	❑ 06 – Not for Profit	❑ 10 – University Affiliated Clinic
❑ 03 – Corporation/Profit Organization	❑ 07 – Private Owner	
❑ 04 – Hospital Based	❑ 08 – HMO	

21. Type of Ownership Code (Please Check One)

❑ 01 – Individual Applicant	❑ 04 – Partner	❑ 07 – Nonprofit Organization
❑ 02 – Board Member/Commissioner	❑ 05 – Corporation	❑ 08 – Trust
❑ 03 – Sole Ownership	❑ 06 – Government Entity	

Remittance Statement Control – Please read instructions on first page before completing!

22. Claims in Process Information (Check one)

- ❑ Y = Print suspended claims only once
- ❑ A = Print all suspended claims (until paid or denied)
- ❑ N = Do not print suspended claims

23. Remittance Sequence (Check one)

- ❑ 1 = By recipient name
- ❑ 2 = By recipient ID

24. Indicate the service(s) for which you are applying and attach proof that the requirement is met.

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 01 – Adult Day Care		
❑ 01 – CARF Accredited	→	IH AH E BI
❑ 02 – Contract with Veterans Administration	→	IH AH E BI
❑ 03 – JCAHCO Accredited	→	IH AH E BI
❑ 57 – Contract with Department of Elder Affairs	→	IH AH E BI
❑ 58 – Letter of certification from Department of Elder Affairs stating agency meets IDEA-IAC 321 Chapter 24 standards	→	IH AH E BI
❑ 59 – Contract with Area Agency on Aging	→	IH AH E BI
❑ 60 – Letter of certification from Area Agency on Aging stating agency meets IDEA-IAC 321 Chapter 24 standards	→	IH AH E BI
❑ 02 – Assistive Devices		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	E
❑ 59 – Contract with Area Agency on Aging	→	E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	E
❑ 06 – Medical equipment and supply dealers (Medicaid Provider # _____)	→	E

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 25 – Behavioral Programming		
❑ 46 – Submit policies, procedures, and forms	→	BI
❑ 26 – Case Management		
❑ 47 – Meets 441 IAC – Chapter 24 Case Management	→	BI
❑ 03 – Chore		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	E
❑ 59 – Subcontract with Area Agency on Aging	→	E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	E
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	E
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	E
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____)	→	E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	E
❑ 11 – Provider certified under the HCBS MR waiver	→	E
❑ Consumer Directed Attendant Care (CDAC)		
❑ 31 – Assisted Living Provider		
❑ 16 – Assisted Living Program accredited/certified by Department of Elder Affairs	→	E
❑ 29 – Agency, Hour / **❑ 30 – Agency, Day**		
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____)	→	IH AH E MR BI PD
❑ 12 – Home Care Agency with written certification from Department of Public Health stating that home care standards and requirements set forth in Department of Public Health rules 641 IAC 80.5(135)-80.7(135) are met	→	IH AH E MR BI PD
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH AH E MR BI PD
❑ 13 – Chore provider contracting with an Area Agency on Aging	→	IH AH E MR BI PD
❑ 14 – Chore provider with letter of approval from an Area Agency on Aging stating that the organization is qualified to provide chore.	→	IH AH E MR BI PD
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	IH AH E MR BI PD
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living	→	IH AH E MR BI PD
❑ 16 – Assisted Living Program accredited/certified by Department of Elder Affairs	→	IH AH MR BI PD
❑ 17 – Adult Day Care provider contracting with an Area Agency on Aging	→	IH AH E MR BI PD
❑ 67 – Adult Day Care provider – CARF accredited	→	IH AH E MR BI PD
❑ 68 – Adult Day Care provider – JCACHO accredited	→	IH AH E MR BI PD
❑ 19 – Adult Day Care provider with contract with Veterans Administration	→	IH AH E MR BI PD
❑ 63 – Adult Day Care provider with a letter of notification from Department of Elder Affairs stating the provider meets 321 IAC Chapter 25	→	IH AH E MR BI PD
❑ 64 – Adult Day Care provider with a letter of notification from an Area Agency on Aging stating the provider meets 321 IAC Chapter 25	→	IH AH E MR BI PD
❑ Counseling		
❑ 32 – Individual / **❑ 33 – Group**		
❑ 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation _____)	→	IH AH
❑ 23 – Hospice (Certificate of License or Medicare Provider # _____)	→	IH AH
❑ 24 – Mental Health Service Provider (Certificate of Accreditation)	→	IH AH

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 34 – Family Counseling		
❑ 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation _____)	→	BI
❑ 23 – Hospice (Certificate of License or Medicare Provider # _____)	→	BI
❑ 24 – Mental Health Service Provider (Certificate of Accreditation)	→	BI
❑ 48 – Qualified brain injury professionals as designated in 441 IAC 83.8(249A)	→	BI
❑ 07 – Home Delivered Meals		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	IH AH E
❑ 59 – Subcontract with Area Agency on Aging	→	IH AH E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	IH AH E
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	IH AH E
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____)	→	IH AH E
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH AH E
❑ 26 – Hospital (Medicare Provider # _____)	→	IH AH E
❑ 06 – Medical equipment and supply dealers (Medicaid Provider # _____)	→	IH AH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	IH AH E
❑ 27 – Restaurant licensed and inspected under Iowa Code chapter 137B	→	IH AH E
❑ 08 – Home Health Aide		
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH AH E MR
❑ 09 – Homemaker		
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____)	→	IH AH E
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH AH E
❑ 10 – Home/Vehicle Modifications (HVM)		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	IH E
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	IH E
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living	→	IH E MR BI PD
❑ 45 – Provider previously enrolled as a waiver Home/Vehicle Modifications provider	→	IH E MR BI PD
❑ 39 – Community Business. Submit current proof of liability and workers compensation coverage	→	IH E MR BI PD
❑ Interim Medical Monitoring & Treatment (IMMT)		
❑ 35 – Home Health Agency – HHA Care ❑ **36 – Home Health Agency – RN Care**		
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH MR BI
❑ 37 – Group Care		
❑ 41 – Licensed child care center	→	IH MR BI
❑ 42 – Registered group child care home	→	IH MR BI
❑ 43 – Registered family child care home	→	IH MR BI
❑ 38 – SCL		
❑ 15 – Provider certified under HCBS Supported Community Living	→	IH MR BI

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 11 – Mental Health Outreach		
❑ 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation _____)	→	E
❑ 12 – Nursing		
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH AH E MR
❑ 13 – Nutritional Counseling		
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	IH E
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH E
❑ 26 – Hospital (Medicare Provider # _____)	→	IH E
❑ 28 – Licensed dietitian approved by an Area Agency on Aging	→	IH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	IH E
❑ 06 – Personal Emergency Response (PERS)		
❑ 39 – Initial Installation **❑ 40 – Monthly**		
❑ 25 – Send information pamphlet	→	IH E MR BI PD
❑ 41 – Prevocational Services		
❑ 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers	→	BI
❑ Respite		
❑ 42 – HHA – Specialized **❑ 43 – HHA – Basic Individual** **❑ 44 – HHA – Group**		
❑ 08 – Home Health Agency (Medicare Provider # _____)	→	IH AH E MR BI
❑ 45 – Non-Facility Care – Specialized **❑ 46 – Non-Facility Care – Basic Individual** **❑ 47 – Non-Facility Care – Group**		
❑ 29 – Provider certified under HCBS MR Respite	→	IH AH E BI
❑ 46 – Submit policies, procedures, and forms	→	MR BI
❑ 48 – Home Care Agency – Specialized **❑ 49 – Home Care Agency – Basic Individual** **❑ 50 – Home Care Agency – Group**		
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # _____)	→	IH AH E MR BI
❑ 51 – Facility Care		
❑ 26 – Hospital (Medicare Provider # _____)	→	IH AH E MR BI
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	IH AH E MR BI
❑ 35 – ICF/MR (Medicaid Provider # _____)	→	IH AH MR BI
❑ 44 – Licensed group living foster care facility	→	IH AH MR BI
❑ 32 – Camp accredited by the American Camping Association	→	IH AH E MR BI
❑ 30 – Adult Day Care Providers	→	IH AH E MR BI
❑ 41 – Licensed child care center	→	IH AH MR BI
❑ 50 – RCF/PMR	→	IH AH MR BI
❑ 17 – Senior Companion		
❑ 37 – Designation by Corporation for National and Community Service	→	E
❑ 19 – Specialized Medical Equipment		
❑ 06 – Medical equipment and supply dealers (Medicaid Provider # _____)	→	BI PD
❑ 40 – Retail and wholesale businesses participating as providers in the Medicaid program (Medicaid Provider # _____)	→	BI PD

Service and Requirements		Circle the waiver(s) for which you are applying
❑ Supported Community Living (SCL)		
❑ 53 – Daily	**❑ 54 – Hourly**	
❑ 46 – Submit policies, procedures, and forms	→	MR BI
❑ 53 – Provider enrolled under HCBS MR Supported Community Living	→	BI
❑ 54 – Provider enrolled under HCBS BI Supported Community Living	→	MR
❑ Supported Community Living – 5 Persons (SCL-5)		
❑ 56 – Daily	**❑ 57 – Hourly**	
❑ 51 – RCF/MR: a. Submit plan to come into compliance with IAC 441 77.37(14)"d"(1) b. Submit copy of 5 bed RCF/PMR licensure	→	MR
❑ Supported Community Living – 8 Persons (SCL-8)		
❑ 59 – Daily	**❑ 60 – Hourly**	
❑ 52 – ICF/MR: a. Submit plan to come into compliance with IAC 441 77.37(14)"d"(1) b. Submit copy of 8 bed ICF/MR licensure	→	MR
❑ 61 – Supported Community Living – Residential-Based (SCL-RB)		
❑ 65 – Group Living Foster Care Facility: a. Submit copy of group living foster care licensure under IAC 441 Chapter 114 b. Submit plan to come into compliance with IAC 441 77.37(23)"e"(3)	→	MR
❑ 66 – Residential Facility for Mentally Retarded Children a. Submit copy of Residential Facility for Mentally Retarded Children under IAC 441 Chapter 116 licensure: b. Submit plan to come into compliance with IAC 441 77.37(23)"e"(3)	→	MR
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living	→	MR
❑ Supported Employment		
❑ 63 - Activities to Obtain a Job **❑ 64 - Job Coaching** **❑ 65 - Personal Care**		**❑ 66 - Enclave**
❑ 46 – Submit policies, procedures, and forms	→	MR BI
❑ 55 – Provider certified under HCBS MR Supported Employment	→	BI
❑ 56 – Provider certified under HCBS BI Supported Employment	→	MR
❑ Transportation		
❑ 67 – Regional Transit Authority		
❑ 38 – Regional Transit Agency recognized by Iowa Department of Transportation	→	E BI PD
❑ 68 – Area Agency on Aging		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	E BI PD
❑ 59 – Subcontract with Area Agency on Aging	→	E BI PD
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	E BI PD
❑ 69 – Mile		
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	E BI PD
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	E BI PD

24. Signature of authorized official										
25. Date			/			/				

Note: Once the application process has been completed, you will receive notification from ACS.

C. Changes

Notify the HCBS waiver office of a decision to:

- Not renew enrollment.
- Withdraw from the provision of any waiver service.

The notice must be in writing and must be received by the Bureau of Long-Term Care 30 days before the date of service or program termination.

D. Adding a New Service for Existing Provider

To add a new AIDS/HIV waiver service when you are an existing AIDS/HIV waiver provider, a new application is required.

Request an application from the Medicaid fiscal agent, as identified in Section I. A. **Provider Enrollment**.

Attach documentation necessary to qualify as a provider of that service.

The Department of Human Services must approve the service before the fiscal agent adds that category of service to its file. No new provider number is issued. If you do not follow this process, your claims for this new service will be denied.

E. Change in Ownership, Agency Name, or Satellite Offices

If the ownership or name change does not involve the issuance of a new federal tax identification number, the agency is not required to complete a new *Medicaid HCBS Waiver Provider Application,* form 470-2917.

Adding a satellite office does not require the completion of a new waiver provider application if the satellite office uses the main office's provider number for billing purposes. If you choose to have a separate provider number for the satellite office, you must file another waiver application.

II. STANDARDS FOR PROVIDERS OF SERVICE

Providers are eligible to participate in the Medicaid program as approved AIDS/HIV waiver service providers based on the standards pertaining to the individual service.

A. Adult Day Care Providers

Adult day care providers shall meet one of the following conditions:

- Contract with the Veterans' Administration to provide adult day health care.
- Meet one of the following conditions individually or as an integral service provided by an organization:
  - Accreditation by the Joint Commission on Accreditation of Health Care Organizations.
  - Accreditation by the Commission on Accreditation of Rehabilitation Agencies.
  - Existence of a contract with or receipt of a point-in-time letter of certification from the Department of Elder Affairs or an Area Agency on Aging pursuant to standards set forth in Department of Elder Affairs rules, 321 Iowa Administrative Code 24.1(231) to 24.8(231).

B. Consumer-Directed Attendant Care Providers

A public or private agency or an individual working independently as a provider of consumer-directed attendant care must be enrolled to provide waiver services.

The following providers may be enrolled to provide consumer-directed attendant care service:

- An individual who contracts with the consumer to provide attendant care service and who is:
  - At least 18 years of age.
  - Qualified by training or experience to carry out the consumer's plan of care pursuant to the Department-approved service plan.
  - Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.
  - Not the recipient of respite services paid through HCBS on behalf of a consumer who receives HCBS.
- Home care providers that have a contract with the Iowa Department of Public Health or have written certification from the Department of Public Health stating they meet the home care standards and requirements set forth in Department of Public Health rules at 641--80.5(135) to 641--80.7(135).
- Home health agencies that are certified to participate in the Medicare program.
- Chore providers subcontracting with Area Agencies on Aging or with letters of approval from the Area Agencies on Aging stating that the organization is qualified to provide chore services.
- Community action agencies as designated in Iowa Code section 216A.93.
- Providers certified under an HCBS waiver for supported community living.
- Assisted living programs that are voluntarily accredited or certified by the Department of Elder Affairs.

- Adult day service providers that:
  - Meet the conditions of participation for adult day care providers under the HCBS ill and handicapped waiver, elderly waiver, AIDS/HIV waiver, or BI waiver, and
  - Have provided a point-in-time letter of notification from the Department of Elder Affairs or an Area Agency on Aging stating the provider also meets the requirements of Department of Elder Affairs rules for non-facility-based respite care in 321 Iowa Administrative Code Chapter 25.

The consumer, parent, guardian, or attorney-in-fact under a durable power of attorney shall be responsible for selecting the person or agency that will provide the components of the attendant care services to be provided.

The Department of Human Services as the single state Medicaid agency has the same oversight responsibility for consumer-directed attendant care providers as it does for providers of any other home- and community-based waiver services.

Providers must demonstrate proficiency in delivery of the services included in a consumer's service plan. Proficiency must be demonstrated through documentation of prior training and experience or a certificate of formal training.

After the interdisciplinary team and consumer determine the adequacy of the training and experience, the consumer and provider shall complete form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*. The service worker designated by the county and the Department service worker must review and approve form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, before the provision of services. Form 470-3372 becomes an attachment to and part of the service plan.

Consumers will give direction and training for activities to maintain independence, which are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare and safety of the consumer.

It is recommended that the provider receive certification of training for the following which are available from the area community colleges:

- Transferring
- Catheter assistance
- Medication aide

C. Counseling Providers

Counseling providers shall be:

- Agencies certified under the community mental health center standards set forth in Department of Human Services rules 441 Iowa Administrative Code Chapter 24, Divisions I and III.
- Agencies that are either:
  - Licensed as meeting the hospice requirements set forth in Department of Inspections and Appeals rules, 481 Iowa Administrative Code Chapter 53, or
  - Certified to meet the standards under the Medicare program for hospice programs.
- Agencies accredited under the mental health service provider standards set forth in Department of Human Services rules, 441 Iowa Administrative Code Chapter 24, Divisions I and IV.

D. Home-Delivered Meals Providers

The following providers may provide home-delivered meals:

- Home health agencies certified to participate in the Medicare program.
- Home care providers meeting the standards set forth in Iowa Department of Public Health rules 641 Iowa Administrative Code 80.5(135), 80.6(135), and 80.7(135).
- Hospitals enrolled as Medicaid providers.
- Nursing facilities licensed pursuant to Iowa Code Chapter 135C.
- Restaurants licensed and inspected under Iowa Code Chapter 137B.

- Community action agencies as designated in Iowa Code Section 216A.93.
- Providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services.
- Area Agencies on Aging as designated in 321 Iowa Administrative Code 4.4(231).
- Providers subcontracting with Area Agencies on Aging or with letters of approval from the Area Agencies on Aging stating the organization is qualified to provide home-delivered meals services.
- Medical equipment and supply dealers certified to participate in the Medicaid program.

E. Home Health Aide Providers

Home health aide providers shall be home health agencies that are certified to participate in the Medicare program.

F. Homemaker Providers

Homemaker providers are agencies that meet one of the following two criteria:

- Agencies that meet the home care standards and requirements set forth in Department of Public Health rules 641 Iowa Administrative Code 80.5(135), 641-80.6(135) and 641-80.7(135).
- Agencies that are certified to participate in the Medicare program.

G. Nursing Care Providers

Nursing care providers shall be home health agencies that are certified to participate in the Medicare program.

H. Respite Care Providers

Respite providers shall be:

- Home health agencies that are certified to participate in the Medicare program.
- Respite providers certified under the HCBS MR waiver.
- Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- Group living foster care facilities for children licensed by the Department according to 441 Iowa Administrative Code Chapters 112 to 116, and child care centers licensed by the Department according to 441 Iowa Administrative Code Chapter 109.
- Camps certified by the American Camping Association.
- Home care agencies that meet the conditions of participation set forth in Section II. F, **Homemaker Providers**.
- Adult day care providers that meet the conditions of participation set forth in Section II. A, **Adult Day Care Providers**.

Providers shall maintain the following information that shall be updated at least annually:

- The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
- An emergency medical care release.
- Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
- The consumer's medical issues, including allergies.
- The consumer's daily schedule which includes the consumer's preferences in activities, food or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- Notifying the parent, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
- Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
- Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
- Ensuring the safety and privacy of the individual. Policies shall at a minimum address fire, tornado, flood and bomb threats.

Facilities providing respite under this waiver shall not exceed the facility's licensed capacity and services shall be provided in locations consistent with licensure.

Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations may not exceed 72 continuous hours.

III. COVERED SERVICES

All services are provided to eligible consumers according to the individualized consumer need as identified in the service plan. Prior to service provision, the provider must obtain documentation of services, units, rates and time period authorized. The documentation should include the following:

- A copy of the Notice of Decision
- A copy of the Service Plan

The following sections list the general exclusion and limitations of waiver services, then detail the coverage requirements for each specific service.

A. Exclusions

1. Services Otherwise Available

Consumers may use services available under the regular State Medicaid Plan in addition to using the waiver services. When the same or similar service is available from an alternate source free of charge, the consumer must also use that service before using the waiver services.

Home health aide and nursing care services are available to persons age 20 or under through the Care for Kids (EPSDT) program when the need for home health aide service exceeds the service available through regular Medicaid.

Nursing and home health aide services for persons age 21 and over may be reimbursed through the waiver only after the regular State Medicaid Plan or alternate-source reimbursement limits are met.

2. Duplicate Services

A person may be enrolled in only one waiver program at a time. For example, a person enrolled in the HCBS AIDS/HIV waiver may not be enrolled in the HCBS MR waiver at the same time.

Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility).

Services may not be simultaneously reimbursed for the same time period. For example, only one provider may be reimbursed for one service during a specified hour, even if two providers arrive at the consumer's home at the same time to provide different services.

3. Services Provided Before Eligibility Determination

Before the Department will reimburse you for HCBS AIDS/HIV waiver services, the following conditions must be met:

- You must be an enrolled Medicaid provider, and
- The consumer must have received both service and financial eligibility approval.

B. Adult Day Care

Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Components of this service are as follows or as indicated in the Iowa Department of Elder Affairs Annual Service and Fiscal Reporting Manual.

- Medical emergency services. Instructions for dealing with medical emergency situations shall be established in writing. The instructions shall include the name and telephone number of a physician on call, written arrangements with a nearby hospital for inpatient and emergency room service, and provisions for ambulance transportation.
- Rehabilitative services. Rehabilitative services shall include physical therapy, occupational therapy, recreational therapy, and speech therapy services which are provided by the day care center directly or indirectly through arrangements with qualified outside sources and which are designed to improve or maintain ability for the client's independent functioning.

- Personal care services. Personal care services shall include assistance with daily activities and training for independent daily living, such as walking, eating, toileting, grooming; and counseling in personal hygiene.
- Nutrition services. The day care center shall provide or make adequate arrangements for a minimum of one meal per day that is of suitable quality and quantity as to supply at least one-third of the daily nutritional requirement. Special diets and supplemental feeding shall be available if the client's needs so warrant.
- Social work services. The day care center shall provide or arrange for social services designed to promote preservation and restoration of the client's physical and mental health. A plan for the preservation and restoration is recorded in the client's record and is periodically evaluated in conjunction with the client's total play of care. At a minimum, the following social services shall be available:
  - Completion of required social history information.
  - Information and referral services.
  - Individual and family counseling.
  - Assessment services in order to determine appropriateness of referrals for adult day care and to contribute to formulation of a plan of care.
  - Consistent participation with the day care team in the formulation, implementation, and evaluation of the client's overall plan at the day care center.
  - Participation in the discharge planning and follow-up of clients.
  - Provision of in service training to day care staff.
- Patient activities services. A plan for independent and group activities shall be developed for each participant in accordance with needs and interests. The plan is incorporated in the overall plan of care and is reviewed, with the client participating, at least quarterly and altered as needed.

  Clients shall be encouraged, but not forced, to participate in planned activities appropriate to their individual needs.

  The facility shall provide adequate indoor and outdoor space and sufficient equipment and materials to support independent and group activities.

- Transportation services. The day care center shall provide or arrange for transportation for clients to and from their homes and to other community facilities utilized in implementing the client's plan of day care.

A unit of service is an extended day (8 to 12 hours), a full day (4 to 8 hours), or a half-day (1 to 4 hours).

C. Consumer-Directed Attendant Care

Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks that the consumer would typically do independently if the consumer were otherwise able.

Consumers who request consumer-directed attendant care (CDAC) and for whom the interdisciplinary team agrees that CDAC is an appropriate service shall have CDAC included in their service plan.

Consumer-directed attendant care may not be simultaneously reimbursed with any other HCBS waiver services.

The consumer, parent, guardian or attorney in-fact under a durable power of attorney for health care determines the components of the attendant care services to be provided with the person who is providing the services to the consumer.

If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

The consumer, parent, guardian, or the attorney in fact under a durable power of attorney for health care must complete and sign form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when consumer-directed attendant care is part of the consumer's individualized service plan. A copy of the completed agreement must be provided to the service worker or case manager before services begin.

The consumer, parent, guardian or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

It is recommended that provisions be made for alternate attendant care service providers to supplement service provision for emergency situations that may arise. These alternate providers should be enrolled and designated in the service plan developed by the service worker or Medicaid case manager.

This will allow the alternate service providers to immediately assume the attendant care service provision whenever necessary. Each provider that is providing the consumer directed attendant care service must complete and sign a separate *HCBS Consumer-Directed Attendant Care Agreement*.

A unit of service is 1 hour (up to 7 hours), or one 8- to 24-hour day provided by an individual or an agency. Bill each service in whole units.

1. Non-Skilled Covered Services

All consumer-directed attendant care services are supportive. The service activities may include helping the consumer with any of the following non-skilled service activities:

- Dressing.
- Bath, shampoo, hygiene and grooming.
- Access to and from bed or wheelchair, transferring, ambulation, and mobility in general.
- Toilet assistance, including bowel, bladder and catheter assistance which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter.

- Meal preparation, cooking, eating and feeding assistance, but not the actual cost of meals.
- Housekeeping services that are essential to the consumer's health care at home.
- Medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider, except for antihypertensives, digitalis preparation, mood altering or psychotropic drugs, or narcotics.
- Minor wound care that does not require skilled nursing care.
- Assistance needed to go to, or return from, a place of employment, and assistance with job-related tasks while the consumer is on the job-site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included.
- Cognitive assistance with tasks such as handling money and scheduling.
- Fostering communication through interpreting and reading services, as well as assistance in the use of assistive devices for communication.
- Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of transportation for the consumer or the provider.

The service activities may not include parenting or child care for or on behalf of the consumer. The consumer-directed attendant care payment does not include the costs of room and board or the cost of transportation.

When a consumer has a consumer-directed attendant care service, the consumer-directed attendant care provider cannot receive respite services. An alternative consumer-directed attendant care provider may be used to provide the consumer-directed attendant care services.

2. Skilled Services Covered

The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated.

- Tube feedings of consumers unable to eat solid foods.
- Assistance with intravenous therapy which is administered by a registered nurse.
- Parenteral injections required more than once a week.
- Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- Rehabilitation services, including, but not limited to, bowel and bladder training, range-of-motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- Colostomy care.
- Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.
- Post-surgical nurse-delegated activities under the supervision of the licensed nurse.
- Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- Preparing and monitoring response to therapeutic diets.
- Recording and reporting of changes in vital signs to the nurse or therapist.

The licensed nurse or therapist must ensure appropriate assessment, planning implementation and evaluation. The licensed nurse or therapist must make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist must be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program before accessing the HCBS waiver.

3. Services Provided by Assisted Living Program

When consumer-directed attendant care is provided by an assisted living program, please note the following:

- The service worker or case manager should be aware of and have knowledge of the specific services included in the assisted living program contract to ensure that:
  - Assisted living program services are not duplicative of consumer-directed attendant care services.
  - Consumer's needs are being addressed.
  - Consumer's unmet needs are included in the care plan.
- Consumer-directed attendant care payment does not include cost of room and board.
- Each consumer must be determined by IFMC to meet ICF/MR level of care.
- The consumer-directed attendant care fee is calculated based on the needs of the consumer and may differ from individual to individual.
- A consumer has the right to choose another provider of waiver services when living in an assisted living facility.

4. Fascimile of Form 470-3372

See the following pages for a fascimile of form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*.

HCBS CONSUMER-DIRECTED ATTENDANT CARE AGREEMENT

This is an agreement between a consumer of services under a Medicaid home- and community-based services waiver and the provider of consumer-directed attendant care.

Name of Consumer	Name of Provider

The Iowa Medicaid Program will reimburse services provided under this agreement when consumer-directed attendant care is part of the consumer's case plan and the social worker or case manager has determined that the prior training and experience of the provider are sufficient to meet the consumer's needs noted in this agreement. However, the consumer agrees not to hold the social worker or case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The Medicaid agency is responsible to insure the health and welfare of the consumer.

Instructions:

The consumer or the consumer's guardian completes this form by entering information about how the provider will meet the standards and responsibilities and the agreed-upon rate of payment. The agreement must be completed and the copies distributed **before** the provider begins providing the service. Both the consumer and the provider must sign the form to signify that they agree to its provisions.

Photocopy of the completed form is given to the consumer, to the provider , and to the nurse or therapist supervising the provision of skilled services, if any.

The original is kept by the service worker or case manager and attached to the care plan.

Agreement:

The consumer and the provider agree that:

1. The provider, as an agency or self-employed contractor, is not an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the provider's responsibility to determine employment status in regards to income tax and social security. Providers of service have no recourse to the Department of Human Services to collect payments due as a result of the agreement between the consumer and the provider of consumer-directed attendant care.

2. This agreement will be reviewed at least annually and whenever there are significant changes in the consumer's situation.

3. This agreement will be renegotiated whenever there is a change: (a) of provider, (b) in the service components to be provided, or (c) in the description of provider activity.

RESPONSIBILITY:	**HOW RESPONSIBILITY IS MET**
Describe the plan for emergencies, including instruction in calling 911 first in all life-threatening situations.	
Describe in detail all of the provider's prior training and experience and how you evaluated it.	
Describe your provisions for managing the provider's services.	
Describe the performance standards for the provider.	
STANDARDS FOR THE PROVIDER:	**CONFIRMATION OF STANDARD**
1. Age (must be at least 18 years old)	
2. Social Security number:	
3. Evidence of basic math, reading, and writing skills (e.g. high school diploma, GED, etc.):	
4. Skills possessed as necessary to perform the attendant care components specified in this agreement:	
5. Evidence of the capability to perform the health maintenance activities specified in this agreement (experience, training, or statement of willingness to receive training before providing care)	
6. Insurance or bond for the activities provided upon consumer request.	❑ Insurance or bonding company: _____ Policy limit: $_____ Policy number: _____ ❑ Requirement is waived:

Describe the components of care to be provided. Enter "Not Applicable" (NA) for components that will not be provided. You may use the letters S (Satisfactory), NI (Needs Improvement) and U (Unsatisfactory) in the column on the right when reviewing the quality of the care provided.

NON-SKILLED SERVICE COMPONENTS	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Dressing.				
Bath, shampoo, hygiene, and grooming.				
Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. (Certification of training which includes demonstration of competence for transferring is available. See **Note** below.)				
Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter. (Certification of training which includes demonstration of competence for catheter assistance is available. See **Note** below.)				
Meal preparation, cooking, eating and feeding assistance (but not the cost of meals themselves).				
Housekeeping services which are essential to the consumer's health care at home.				

Note: Certification is available through the community colleges. There is no funding available through the waivers to cover this training cost.

NON-SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Medications ordinarily self-administered, including those ordered by a physician or other qualified health care providers which are not antihypertensives, digitalis preparations, mood altering, or psychotropic drugs or narcotics. (A medication aide course is available through the area community colleges.)				
Minor wound care which does not require skilled nursing care.				
Assistance needed to go to or return from a place of employment but not assistance to the consumer while the consumer is on the job site.				
Cognitive assistance with money handling and scheduling tasks.				
Fostering communication through interpreting and reading services, as well as assistive devices for communication.				
Assisting or accompanying the consumer in using transportation essential to the health and welfare of the consumer, but not the cost of transportation.				

Service activities include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The cost of this supervision shall be paid from private insurance and other third party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program. The nurse or therapist must retain accountability for actions that are delegated and ensure appropriate assessment, planning, implementation, and evaluation.

The nurse or therapist shall make on-site supervisory visits every two weeks, with the provider present and document to this record. This nurse or therapist agrees to supervise these service components delivered by this provider:

Name and telephone number of supervising nurse or therapist:

Describe the components of skilled care to be provided. Enter "Not Applicable" (NA) for components that will not be provided. You may use the letters S (Satisfactory), NI (Needs Improvement) and U (Unsatisfactory) in the column on the right when reviewing the quality of the care provided.

SKILLED SERVICE COMPONENTS	**DESCRIPTION OF PROVIDER ACTIVITY**	**EVALUATION**		
		S	**NI**	**U**
Tube feedings of consumers unable to eat solid foods.				
Assistance with intravenous therapy administered by a licensed nurse.				
Parenteral injections required more than once a week.				
Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.				
Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.				

SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.				
Rehabilitation services includes bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.				
Colostomy care.				
Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions).				
Postsurgical nurse delegated activities under the supervision of the licensed nurse.				

SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION S	NI	U
Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g. hypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. A medication aid course is available through the area community colleges.				
Preparing and monitoring response to therapeutic diets.				
Recording and reporting of changes in vital signs to the nurse or therapist.				

The basis of reimbursement is the fee agreed upon between the consumer and the provider, within the upper limits allowed in the program and as established in the case plan or individual comprehensive plan (ICP). The agreed upon reimbursement rate to the provider is as follows (*complete one line only*):

HCPCS Code	Provider Type	Fee per Unit	Maximum Units	Upper Limit
W1265	Agency provider not an assisted living provider	$_____ per hour, up to	_____hours	$18.49 per hour (1-7 hrs)
W1266	Agency provider not an assisted living provider	$_____ per day, up to	_____ days	$106.82 per day (8-24 hrs)
W1267	Individual provider	$_____ per hour, up to	_____ hours	$12.33 per hour (1-7 hrs)
W1268	Individual provider	$_____ per day, up to	_____ days	$71.90 per day (8-24 hrs)
W2517	Assisted living provider	$_____ per month	1 month	$1,052 per month, not to exceed $34.60 per day

Consumer Signature	Date

I agree to the services written in this form and:

- To submit to a criminal records check.
- That my protective services records may be checked for reported or confirmed abuse.
- To hold the Department of Human Services harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this agreement by any and all persons.

_____ Provider Signature

_____ Date

ADDITIONAL INFORMATION ON BILLING:

Each service must be billed in whole units. Submit billings for all consumer-directed attendant care to ACS (the Medicaid fiscal agent) on form 470-2486, *Claim for Targeted Medical Care*. Both the consumer and the provider must sign and date the *Claim for Targeted Medical Care*. Obtain copies of this form from ACS, Provider Relations, at 1-800-338-7909.

Submit claims to ACS on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for an entire month's service by the tenth of the month following the month of service. EXAMPLE: Ten hours of consumer-directed attendant care service was provided during the month of June. The claim for June's service should be submitted by the tenth day of July.

D. Counseling

Counseling services are face-to-face mental health services provided to the consumer and caregiver to facilitate home management of the consumer and prevent institutionalization. Services must be provided by a mental health professional.

A "mental health professional" means a person who meets all the following conditions:

- Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine (MD) or doctor of osteopathic medicine and surgery (DO), and
- Holds a current Iowa license when required by the Iowa licensure law, and
- Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness and needs of persons and in providing appropriate mental health services for those persons.

Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation, and support to cope with a terminal illness.

Counseling services may be provided both for the purpose of training the consumer's family or other caregiver to provide care, and for the purpose of helping the consumer and those caring for the consumer to adjust to the consumer's disability or terminal condition. Counseling services may be provided to the consumer's caregiver only when included in the service plan for the consumer.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver consumer or the waiver consumer and the consumer's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons in the group exceeds six, by the actual number of persons who comprise the group.

E. Home-Delivered Meals

Home-delivered meals means meals prepared elsewhere and delivered to an HCBS AIDS/HIV consumer at the consumer's residence.

Each meal shall ensure the consumer receives a minimum of one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

F. Home Health Aide Services

Home health aide services are unskilled medical services that provide direct personal care. This service may include:

- Observation and reporting of physical or emotional needs.
- Assistance with bath, shampoo, or oral hygiene.
- Assistance with toileting.
- Assistance with ambulation.
- Helping consumers in and out of bed.
- Helping a consumer reestablish activities of daily living.
- Assisting with oral medications ordinarily self administered and ordered by a physician.
- Performing incidental household services which are essential to the consumer's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

Services are to be provided in the home. A unit of service is a visit.

Home health services do not include:

- Homemaker services such as cooking and cleaning.
- Services which meet the intermittent guidelines under Medicaid.
- Services which are provided under the EPSDT authority.

Services may not duplicate any regular Medicaid or waiver services provided under the state plan.

For persons aged 21 or over, the waiver provides coverage for home health aide services that are needed beyond the intermittent home health aide services available through regular Medicaid. "Intermittent" home health aide services may include up to 28 hours of service per week, when services are medically necessary.

Home health aide services are available to Medicaid-eligible persons under the age of 21 through Care for Kids (EPSDT).

G. Homemaker Services

Homemaker services are those services provided when the consumer lives alone or when the person who usually performs these functions for the consumer needs assistance with performing the functions. A unit of service is one hour.

Components of the service are directly related to the care of the consumer and include:

- Essential shopping: Shopping for basic need items such as food, clothing or personal care items, or drugs.
- Limited housecleaning: Maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the consumer, and washing dishes.
- Accompaniment of the consumer to medical or psychiatric services or, for children aged 18 and under, to school.
- Meal preparation: Planning and preparing balanced meals.

H. Nursing Care

Nursing care services are services provided by licensed agency nurses to consumers in the home which are ordered by and included in the plan of treatment established by the physician. The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the consumer and included in the Iowa Board of Nursing scope of practice guidelines.

A unit of service is one visit.

I. Respite Care

Respite care services are services provided to the consumer that give temporary relief to the usual caregivers and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

Respite care is not to be provided to persons during the hours in which the usual caregiver is employed, except when the provider is a camp.

Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

Respite services provided by home health agencies, home care agencies, and other non-facility providers are divided into specialized respite, group respite, and basic individual respite, with separate rates of payment.

- Specialized respite means respite provided on a staff-to-consumer ratio of one-to-one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.
- Group respite is respite provided on a staff-to-consumer ratio of less than one-to-one.

Basic individual respite means respite provided on a staff-to-consumer ratio of one-to-one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite.

A unit of service is one hour for all respite services.

A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code Chapter 135C.

When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

IV. BASIS OF PAYMENT

A *Financial and Statistical Report for Purchase of Service Contracts* is required for the following types of respite providers:

- Home health agencies providing group respite.
- Non-facility providers of specialized, basic individual and group respite.
- Camps.
- Home care agencies providing specialized, basic individual and group respite.

Providers reconciling respite services are not required to submit the HCBS Supplemental Schedule D-4 from form 470-3449.

All financial and statistical reports must meet the specifications described in this section. You must complete the form or have responsibility for its content, if it is prepared by someone outside the agency.

A. Maintenance and Retention of Financial and Statistical Records

The financial information included in forms 470-0664 and 470-3449 must be taken from your financial and statistical records and must be verifiable by qualified auditors. To provide the required cost data and not impair comparability, you must maintain financial and statistical records in a consistent manner from one period to another.

Maintain sufficient financial and statistical records to document the validity of reports you submit to the Department. This includes program and census data. Failure to maintain records to support your cost reports may result in termination of your HCBS certification.

These records include, but are not limited to:

- All canceled checks, deposit slips, and invoices (paid and unpaid).
- Audit reports (if any).
- Board of director's minutes (if applicable).
- Capital asset schedules.
- Documentation of units of services provided to consumers.
- General ledger reconciliation to financial and statistical report.
- Loan agreements and other contracts.
- Payroll information.
- Reviewable, legible census reports.

Maintain these forms and all financial and statistical records to support them for a minimum of five years. Make these reports and records available to authorized representatives and agents of the Department and of the United States Department of Health and Human Services, upon request.

B. Submission of the Financial and Statistical Reports

Forms 470-0664 and 470-3449 are due in to the Department by September 30 of each year for reconciliation of respite rate reimbursement. You may obtain a 30-day extension for submitting the cost reports by submitting a letter to the Bureau of Long-Term Care by September 30. No extensions will be granted beyond 30 days.

Failure to submit a report by September 30 or an extended deadline granted shall **reduce payment** to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time **no** further payments will be made.

If you have multiple-program agencies, you must also submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

The Department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

Forward the original and one copy, both having original signatures of an officer of the facility, to:

Ryun, Givens, Wenthe & Co
1641 48th St, Suite 150
West Des Moines, Iowa 50266-6722

If you choose to leave the HCBS program or terminate a service, submit a final cost report within 60 days of termination for reconciliation of respite rates.

C. Facsimiles of Forms 470-0664 and 470-3449

See the following pages for samples of the *Financial and Statistical Report for Purchase of Service Contracts*, form 470-0664, and the *Supplemental Schedule*, form 470-3449.

Page 44 was intentionally left blank.

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT FOR PURCHASE OF SERVICE CONTRACTS

CERTIFICATION PAGE

Agency Name			IRS ID No.
Address			Contract No.
City		State	Zip Code
Period of Report:	From	To	Date of Fiscal Year End
Administrator Name			Telephone No.
Name of Person to Contact if Questions About the Report			Telephone No.

Does agency have an independent audit? ❑ Yes, for year ending _____ ❑ No

Has a copy of the latest independent audit been submitted? ❑ Yes ❑ No

A. Type of Control: ❑ Government ❑ Nonprofit Organization ❑ Proprietary

B. Accounting Basis: ❑ Accrual ❑ Modified Cash ❑ Cash

C. Statistical Data for Period of Report:

1. Service code.							
2. If subject to licensure, number of clients licensed for.							
3. Number of units of service (licensed or staffed)							
a. Type of unit (hourly, daily, etc.)							
4. Total number of units of service provided.							
5. Total number of units of service provided for:							
a. DHS clients							
b. Other clients							
6. Percent of units provided to unit capacity (divide line 4 by line 3)							
7. Are the rates received from non-DHS clients the same as, or more than, POS rates for the same service: Circle yes or no, for each service. If no, explain:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

D. Form of Certification by Officer or Administrator of Provider Agency:

I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared from the books and records of the facility in accordance with instructions contained in this report, and the allowable cost of care excludes expenses that were not necessary to provide this care.

Signature Officer or administrator of facility	
Title Officer or Administrator	Date

E. Statement of Preparer (if other than agency)

I have prepared this report and to the best of my knowledge and belief, it represents true and accurate data of the agency for the period stated above.

Signature of Preparer	Date

F. Statement of Project Manager

I have reviewed this report prior to submitting it to the State (Department of Human Services, Bureau of Purchased Services, Purchase of Service Unit).

Signature of Project Manager	Date

Provider Agency		
Period of Report	From	To

SCHEDULE A: REVENUE REPORT

Revenues:	**Total Revenue**	**Revenue for Schedule D Expense Deduction***
Fee for Service:		
Iowa State Department of Human Services	$	
County Board of Supervisors		
Private Clients		
Department of Education (Voc Rehab) (service fees only)		
United Way (service fees only)		
Social Security, SSI, SSA		
Other		
Service, Reimbursement or Investment Income:		
Work Services Revenues	$	$
Food Reimbursement (DOE)		
Investment Income		
Other (attach schedule)		
Contributions: (Schedule must be attached:)		
United Way: Contributions not restricted or appropriated** to a specific individual	$	
Restricted to specific individuals*		$
Other: Contributions not restricted or appropriated** to a specific individual		
Restricted to specific individuals*		$
Government Grants:		
Total Revenue	$	*$

* Income which must be deducted from total service expense on Schedule D.

** Agencies must have documentation or support which identifies purposes of contributions reported.

Provider Agency		
Period of Report	From	To

SCHEDULE B: STAFF NUMBERS AND WAGES

Job Classification and Title	Number of Staff			Gross Wages
	Full Time	Part Time	FTEs	
Administrative #2110 Job Title _____				
Administrative Total				
Professional #2120 Job Title _____				
Professional Total				
Direct Client Care #2130 Job Title _____				
Direct Client Care Total.....				
Clerical #2150 Job Title _____				
Clerical Total.....				
Other Staff Wages #2190 Job Title _____				
Other Staff Wages Total				
Total: ALL JOB CLASSIFICATIONS AND TITLES				

The maximum amount of wages chargeable to Purchase of Services for any one employee is $40,000 annually. If an employee is paid in excess of $40,000, the excess must be reported as "Other Nonreimburseable Costs" in column 3 of Schedule D or charged to Excluded Services (use column 5 of Schedule D).

Provider Agency		
Period of Report	From	To

SCHEDULE C: PROPERTY AND EQUIPMENT DEPRECIATION AND RELATED PARTY PROPERTY COSTS

PROVIDER -OWNED EQUIPMENT BUILDINGS

Description:	Original Cost	Depreciation Recorded Prior Years	Method	Annual % Rate	Recorded Depreciation Expense	Straight-Line Depr.
Equipment:						
Building equipment						
Departmental equipment						
Other equipment						
Office furniture and fixtures						
Motor vehicles						
Total						
Buildings:						
Buildings						
Additions						
Leasehold improvements						
Other						
Total						
Total Equipment and Buildings						

RELATED PARTY PROPERTY COST

1. Is any property being leased from a party "related to provider" using the definitions in the contract and the Provider Handbook? ❑ Yes ❑ No

2. Schedule of Lessor's Costs:

   If answer to number 1 is yes, provide lessor's costs in the space below.

   Depreciation on property _____

   Property taxes _____

   Mortgage interest on property _____

   Insurance _____

   Other (describe) _____

   Total _____

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

						Direct Service Cost					
		1	2	3	4	5	6	7	8	9	10
Acc No.	**Account Title**	**Total Expense**	**Fund-Raising Cost**	**Other Nonreim-burseable Costs**	**Adjusted Cost: Col 1 minus Cols 2 & 3**						**Indirect Service Cost**
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	**TOTAL WAGES**										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	**TOTAL BENEFITS**										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	**TOTAL PAYROLL TAXES**										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	**TOTAL PROFESSIONAL FEES**										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	**TOTAL SUPPLIES**										
2600	**TELEPHONE AND TELEGRAPH**										
2700	**POSTAGE AND SHIPPING**										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	**TOTAL OCCUPANCY EXPENSE**										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

		11	12	13	14	15	16	17	18	19	20
Acc No.	**Account Title**										
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	**TOTAL WAGES**										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	**TOTAL BENEFITS**										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	**TOTAL PAYROLL TAXES**										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	**TOTAL PROFESSIONAL FEES**										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	**TOTAL SUPPLIES**										
2600	**TELEPHONE AND TELEGRAPH**										
2700	**POSTAGE AND SHIPPING**										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	**TOTAL OCCUPANCY EXPENSE**										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		Direct Service Cost									
		1	2	3	4	5	6	7	8	9	10
Acc No.	**Account Title**	**Total Expense**	**Fund-Raising Costs**	**Other Nonreim-burseable Costs**	**Adjusted Cost: Col 1 minus Cols 2 & 3**						**Indirect Service Cost**
3100	**OUTSIDE PRINTING AND ART WORK**										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	**TOTAL TRANSPORTATION**										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	**TOTAL CONFERENCES AND CONVENTIONS**										
3400	**SUBSCRIPTIONS AND PUBLICATIONS**										
3510	Clothing and Personal Needs										
3520	Other										
3500	**TOTAL ASSISTANCE**										
4100	**ORGANIZATION MEMBERSHIPS**										
4200	**AWARDS AND GRANTS**										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	**TOTAL EQUIPMENT REPAIRS & PURCHASE**										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	**TOTAL DEPRECIATION**										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	**TOTAL MISCELLANEOUS**										
	TOTAL EXPENSES										
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

		11	12	13	14	15	16	17	18	19	20
Acc No.	**Account Title**										
3100	**OUTSIDE PRINTING AND ART WORK**										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	**TOTAL TRANSPORTATION**										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	**TOTAL CONFERENCES AND CONVENTIONS**										
3400	**SUBSCRIPTIONS AND PUBLICATIONS**										
3510	Clothing and Personal Needs										
3520	Other										
3500	**TOTAL ASSISTANCE**										
4100	**ORGANIZATION MEMBERSHIPS**										
4200	**AWARDS AND GRANTS**										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	**TOTAL EQUIPMENT REPAIRS & PURCHASE**										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	**TOTAL DEPRECIATION**										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	**TOTAL MISCELLANEOUS**										
	TOTAL EXPENSES										
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE E: COMPARATIVE BALANCE SHEET

ASSETS, LIABILITIES, AND EQUITY	BALANCE AT END OF Current Period	BALANCE AT END OF Prior Period
ASSETS:		
Cash	$	$
Receivable from clients		
Receivable from others		
Property and equipment:		
Land		
Buildings and equipment		
Less allowance for depreciation		
Net property and equipment		
Investments and other assets		
TOTAL ASSETS.....		
LIABILITIES AND EQUITY:		
Accounts payable	$	$
Accrued taxes (payroll and property)		
Other liabilities		
Notes and mortgages		
Total liabilities		
Equity or fund balance		
TOTAL LIABILITIES AND EQUITY		

RECONCILIATION OF EQUITY OR FUND BALANCE

TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD	$
Add:	
TOTAL REVENUE from Schedule A	$
Other revenue. Explain	
Deduct:	
TOTAL EXPENSES from Schedule D	
Other expenses. Explain	
TOTAL EQUITY OR FUND BALANCE END OF PERIOD	$

Provider Agency		Vendor No.
Period of Report:	From	To

SCHEDULE F: COST ALLOCATION PROCEDURES
(To be completed by providers which offer more than one service)

Costs are allocatable to a particular service, such as a grant, project, or other activity, in accordance with the relative benefits received. A cost is allocatable to a service if it is treated consistently with other costs incurred for the same purpose in like circumstances, and if it:

(1) Is incurred specifically for the service,

(2) Benefits the service and can be distributed in reasonable proportion to the benefits received, and

(3) Is necessary to the overall operation of the organization, although a direct relationship to a particular service cannot be shown.

Any cost allocatable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies or to avoid other restrictions imposed by law or terms of an award.

DIRECT COSTS:	Yes	No
1. Do you have a cost allocation plan which describes the methods you use in distributing joint costs to services or activities?	❑	❑
2. If you do not have a cost allocation plan describing the methods followed, do you have accounting workpapers available to support joint direct cost allocations?	❑	❑
3. Is your method of allocating joint service cost consistently followed from year to year?	❑	❑
4. Are costs allocated to services in reasonable proportion to benefits received?	❑	❑
5. Are service income deductions allocated in a manner which is consistent with the costs incurred in generating the income?	❑	❑
6. Additional comments regarding allocation of joint service costs:	❑	❑

INDIRECT COST:

1. Are indirect costs distributed on a basis of total direct service or cost?	❑	❑
2. If indirect costs are not allocated on the basis of total direct service costs, what was the basis used?		
3. Is the basis for distributing indirect cost the same as that used in the previous year?	❑	❑

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 1

A	B	C	D	E	F	G	
		Shelter Care					
Account Number	Account Title	Allowable Attribution Cost	Allowable Allocation of Cost	Total Costs	Allocation of Total Cost to: Maintenance	Allocation of Total Cost to: Service	Basis of Allocation
from 2190	Food Service & Maintenance Workers Salaries					**********	Definition
% of 2200	Food Service & Maintenance Workers Benefits					**********	Definition
% of 2300	Food Service & Maintenance Workers Payroll Taxes					**********	Definition
2130	Direct Care Staff Salaries						Time
% of 2200	Direct Care Staff Benefits						Time
% of 2300	Direct Care Staff Payroll Taxes						Time
from 2120	Other Direct Staff (C1 in/pgm. Supv/SW-Thpst/Nurse)						Time
% of 2200	Other Direct Staff Benefits						Time
% of 2300	Other Direct Staff Payroll Taxes						Time
from 2110	Other Admin. Staff (Clinical/Pgm Supv or Mgr) Salaries						Time
% of 2200	Clinical Supervisor Benefits						Time
% of 2300	Clinical Supervisor Payroll Taxes						Time
2450	Medical & Psychological Services Purchased				**********		Definition
2490	Other Non-Medical Services Purchased				**********		Definition
2530	Medical Supplies					**********	Definition
2540	Recreation ("Family-Like") & Craft Supplies					**********	Definition
	Formalized Non "Family-Like" Recreation				**********		Definition
2550	Food					**********	Definition
3510+352	Clothing, Personal Needs, School Supplies, and Other					**********	Definition
2810	Rent of Space						Sq Ft. -
2820	Building and Grounds Supplies						Sq Ft. -
2830	Utilities						Sq Ft. -
2840	Care of Building and Grounds						Sq Ft. -
2870	Interest on Building and Grounds						Sq Ft. -
2880	Insurance and Property Taxes						Sq Ft. -
2890	Other Occupancy Expenses						Sq Ft. -
Schedule	Part 1 TOTALS						Sq Ft. -Use
			Service/Maintenance Percentages				

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 2

Residual Cost NOT Included in Schedule G, Part 1	Gross Total Attributable to: Shelter
Remainder of Program Direct Costs (Total Program Schedule D Direct - Part 1 Direct)	
Remainder of Program Indirect Cost (Total Program Schedule D Direct - Part 1 Indirect)	
PROGRAM TOTALS for PART 2	

UNIT COST DETERMINATION

SERVICE PERCENTAGE FROM SCHEDULE G PART 1	
TOTAL PART 2 SERVICE COST	
TOTAL SERVICE COST FROM PART 1	
GRAND TOTAL SERVICE COST	
DEDUCTIONS FROM SERVICE COST FROM SCHEDULE D	
GRAND TOTAL SERVICE COST AFTER DEDUCTIONS	

MAINTENANCE PERCENTAGE FROM SCHEDULE G PART 1	
TOTAL PART 2 MAINTENANCE COST	
TOTAL MAINTENANCE COST FROM PART 1	
GRAND TOTAL MAINTENANCE COST	
DEDUCTIONS FROM MAINTENANCE COST FROM SCHEDULE D	
GRAND TOTAL MAINTENANCE COST AFTER DEDUCTIONS	

UNITS OF SERVICE	
SERVICE COST PER UNIT	
MAINTENANCE COST PER UNIT	
TOTAL COST PER UNIT	`

ALLOCATION OF STAFF TIME WORK SHEET

(Use separate form for each staff type)

TYPE OF STAFF: _____

Enter the percent of time spent on maintenance activities here:	_____	LINE 1
Enter the percent of the time spent on service activities here:	_____	LINE 2
Add line 1 and line 2 and enter result here:	_____	LINE 3
Divide line 1 by line 3 and enter result here:	_____	LINE 4
Divide line 2 by line 3 and enter result here:	_____	LINE 5
Enter the percent of time spent on administrative activities here:	_____	LINE 6
Multiply line 4 by line 6 and enter result here:	_____ (This is the percentage of administrative time allocated to maintenance.)	LINE 7
SUBTRACT line 7 from line 6 and enter result here:	_____ (This is the percentage of administrative time allocated to service.)	LINE 8
ADD line 1 and line 7 and enter result here:	_____ (This is the total percentage of time allocated to maintenance. Use this percentage to allocate staff cost to maintenance.)	
ADD line 2 and line 8 and enter result here:	_____ (This is the total percentage of time allocated to service. Use this percentage to allocate staff cost to service.)	

* The combined percent of time spent on maintenance, service, and administrative activities should total 100%.

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Iowa Department of Human Services

SUPPLEMENTAL SCHEDULE

HCBS SUPPLEMENTAL SCHEDULE-D-1 TO FORM 470-0664

CALCULATION OF CONSUMER ITEM LIMITS

(Complete one schedule for each living site or program)

Program					
Column(s) From Schedule D					
From Schedule D: Line 3290 - Other Related Transportation					
Line 3520 - Other					
Line 4320 - Other Equipment Repair and Purchase					
Total					
Divided by the Number of Unduplicated Consumers (from provider records					
Average Amount per Consumer					
Limit	1570	1570	1570	1570	1570
Variance					

This calculates an average per consumer. The facility is still responsible for justifying actual costs per consumer that exceed the limit.

HCBS SUPPLEMENTAL SCHEDULE-D-2 TO FORM 470-0664

CALCULATION OF INDIRECT COST LIMITS

(Complete one schedule for each living site/program)

Program					
Column(s) from Schedule D					
Total Service or Maint. Cost After Allocation of Indirect					
Less: Direct Costs (HCBS program columns only):					
Line 2120 - Professional Direct Staff					
Line 2130 - Other Direct Staff					
Line 2200 - Total Benefits for Direct Staff					
Line 2300 - Payroll Taxes for Direct Staff					
Line 3210 - Mileage and Auto Rental					
Line 3250 - Agency Vehicle Expense					
Line 3290 - Other Related Transportation					
Line 3520 - Other					
Line 4320 - Other Equipment Repair and Purchase					
Subtotal of Direct Cost					
Calculated Indirect Cost (Total Costs Net of Direct Costs)					
Limitation (20% of the Subtotal of Direct Cost)					
Difference (to Schedule D-3 if exceeds limit)					

HCBS SUPPLEMENTAL SCHEDULE-D-3 TO FORM 470-0664

RECONCILIATION OF COST AND PAYMENTS

(Complete by including all programs)

Program					
Column(s) From Schedule D					
Unadjusted Total Cost After Deductions-Schedule D					
Less: Adjustment for Indirect Cost - Schedule D-2					
Adjusted Costs					
Divided by Total Units (certification page section C, line 4)					
Total Unit Cost					
Lower of Unit Cost or Maximum Reimbursement Rate					
Multiplied by DHS Units (certification page section C, line 5)					
Total DHS Cost					
Comparison of Costs and Payments:					
Revenues Billed (from provider records)*					
Less DHS Cost (above)					
Subtotal					
Less DHS Cost X 2.5%					
Balance Due Medicaid Program **(If negative, no balance is due.)**					

*For reconciliation of revenues billed, see page 2.

HCBS SUPPLEMENTAL SCHEDULE-D-3 TO FORM 470-0664

RECONCILIATION OF COST AND PAYMENTS

(Complete by including all programs)

Programs					
Column(s) From Schedule D					
Total Payments Received for Current Period					
Payments Not Yet Received for Current Period					
Total Revenues Billed					

Note: The section below need not be completed for the reporting period ended 6/30/97. This information will need to be collected for future reporting periods.

FOR USE IN CALCULATION OF IN- AND OUT-OF-COUNTY RATES FOR SCL HOURLY SERVICES:

Travel Allocation	In	Out	Total
Time Spent			

HCBS SUPPLEMENTAL SCHEDULE-D-4
TO FORM 470-0664

For Projected Rates:

Effective date _____

☐ All Consumers-Site Rate
OR
☐ Consumer _____ of _____

DAILY RATE WORKSHEET

Site Name: _____

No. of Consumers Served: _____

Form 1703-0 Line:

2120 - Professional Direct Staff (Direct Hours _____)	
2130 - Other Direct Staff (Direct Hours _____)	
2200 - Direct Staff Benefits	
2300 - Direct Staff Payroll Taxes	
3210 - Mileage and Auto Rental (Numbers of Miles _____)	
3250 - Agency Vehicle Expense (Number of Miles _____)	
3290 - Other Related Transportation*	
3520 - Other (Consultation Expenses)*	
4320 - Other Equipment Repair and Purchase*	
Total Direct Expense	
Indirect Expense (limited to 20% of direct expense)	
Total Cost	
Number of Units Provided	
Unit Cost	

*The sum of these lines is limited to $1570 annually per customer

Request to Exceed the Unique Rate Maximum:

Explanation of reasons for exceeding maximum (i.e. ratio of mid management staff to consumers on caseload or percentage of time charged. Hourly wage of direct staff, description of staffing pattern, description of other support services and resources sought and not available, description of expenses listed in lines 3290, 3520, and 4320 and identification of other resources sought and not available.)

For Projected Rates:

I certify that I have examined the accompanying schedules of expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses that were not necessary to provide this care.

SIGNED (Officer or Administrator of Facility)	Date

HCBS SUPPORTED COMMUNITY LIVING INITIAL HOURLY RATE CALCULATION SUPPORTIVE WORKSHEET

Part A: Billable Hours (for an annual period)

ITEM	Instructions	Column 1	Column 2
TOTAL AVAILABLE HOURS: ___FTEs X 2,080 hours/year	From FSR: Schedule B (professional and direct only);-should equal D-4, 2120 + 2130		
VACATION & HOLIDAYS (subtract): ___FTEs X_____days X 8 hours/days =	FTEs (same as above); number of days for vacation and holidays per year		
SICK LEAVE (subtract): ___FTEs X_____days X 8 hours/days =	FTEs (same as above); average sick leave usage per year per person		
ADMINISTRATION (subtract): ____% X____hours (see total available hours shown above)=	% of time professional and direct staff spend doing administrative work		
TRAVEL (to consumer locations): (subtract): In county _____%X____hours (see total available hours shown above)= Out of county ___%X____hours (see total available hours shown above)=	% of time professional and direct staff spend traveling from site to site in county and, if applicable, out of county		
UNBILLABLE HOURS (subtract): ____% X____hours (see total available hours shown above)=	% of down time: time when planned activity cannot or did not occur (maximum of 5%)		
TOTAL ANNUAL BILLABLE HOURS			

Part B: Hourly Rate

DIRECT COST (annual amount)	From 470-0664, Schedule D		
INDIRECT COST	From 470-0664, Schedule D (maximum is 20% of direct)		
TOTAL HOURLY COST	Sum of direct and indirect		
DIVIDED BY TOTAL BILLABLE HOURS FROM ABOVE			
HOURLY RATE			

Use Column 1 for calculating the hourly rate for supported community living services provided in the county in which you are located.

Use Column 2 for calculating the hourly rate for supported community living services provided in any other county. (The assumption is that there will be one hourly rate for out-of-county supported community living services, whether it is for one county or twenty counties.)

Signature	Signature
HCBS Agency	CPC County

D. Instructions for Completing Financial and Statistical Reports

Enter identifying information at the top of each schedule. All information called for in the schedules must be furnished unless it does not apply to your agency.

The cost reporting period is from July 1 through June 30. For providers participating in the program as of July 1, the report covers the 12-month period of July 1 through June 30. For those entering the program after July 1, the reporting period is from the beginning of providing BI waiver services through June 30.

New providers not having historical costs may complete the report using projected costs. Only the certification page and Schedule D of form 470-0664 and the *Supplemental Schedule* (form 470-3449) are required.

Adjustments to convert to an accrual basis of accounting are required if your records are maintained on another accounting basis. The intent of these adjustments is to obtain information concerning costs of providing care and services to consumers on a basis that is fair and comparable among providers of the service.

Providers who are also providing services not contracted for under the home- and community-based BI waiver contracts should complete the cost apportionment in accordance with recognized methods and procedures for a fair presentation of expense attributable to services provided under the contract. Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

Reporting of in-county and out-of-county rates is required for agencies that maintain an out-of-county supported community living service (SCL) paid at hourly rates. In- and out-of-county rates may be set up through an initial projection and then maintained by special reporting on the annual *Financial and Statistical Report.* "In-county" is the county where the main office is located. "Out-of-county" is all other counties where services are provided.

Travel time needs to be accumulated by "in" and "out" counties. SCL hourly costs will be allocated between the in and out of county designations based on travel time. Hourly units provided for SCL also need to be accumulated on an "in county" versus an "out of county" basis in order to continue to set two separate rates.

1. Certification Page

The purpose of the certification page is to report agency statistical information and record the signature of authorized officer of the agency.

Agency Name and **Address:** Enter the official name and address of the agency. Generally this is the name and address which appears on the license or official agency letterhead.

IRS ID No.: Enter the number assigned the facility for tax purposes (federal withholding, etc.).

Contract No.: Enter the contract number assigned at certification.

Period of report: Enter the dates for which the current information is being provided.

Date of Fiscal Year End: Enter the ending date for your fiscal year.

Names and Telephone Numbers: Self-explanatory.

Audit: Indicate if the agency had a certified public accounting firm perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.

Type of Control: Indicate the ownership under which the agency is conducted.

Accounting Basis: Indicate the basis on which you keep your books.

- Accrual: Recording revenue when earned and expenses when incurred.
- Modified Cash: Combination of certain cash and accrual method of accounting.
- Cash: Recording revenue when received and expenses when paid.

If you do not use the accrual basis of accounting, you must adjust record amounts to the accrual basis. Keep the accounting work papers used in adjusting your records from cash to accrual.

Statistical Data: Enter service codes as entered on Schedule D. Each program and living site should be shown separately.

Enter the appropriate number of units for the reporting period. Billable time means direct support contact with the consumer. For daily units, the number of units of services staffed should be based upon a 365-day period (366 days during a leap year).

Total hours at the end of the month. Round partial units up to the next unit. Divide billable hours equally among consumers when the consumer to staff ratio is greater than 1:1.

Signatures: The report must be reviewed and signed by an authorized officer or administrator of the agency. If the report is prepared by someone other than an employee of the agency, that person must sign.

2. Schedule A

The purpose of Schedule A, Revenue Report, is to report total agency income and the income allocated to the specific services and programs. Report all revenues, including those from excluded or non-home- and community-based BI waiver programs.

Report the total revenues or gross income in the column headed "Total Revenue." Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

Revenues are generally broken down into three classifications for purposes of completing this report: fees for service, other income, and contributions. These revenue sources are further explained as follows:

- Fees for services represent income earned by the provider as a result of performing services to or for consumers. The fees might be paid by third parties on behalf of consumers for which services were performed.
- Service, reimbursement or investment income includes program revenues from the sale of products, food reimbursements for the Department of Education, and investment income which is not from restricted or appropriated contributions and which is held separate and not commingled with other funds. Additional other income items may be applicable. If so, identify them accordingly or support them by an accompanying schedule.
- Contributions include all United Way funding, other donations, and government grants that are not designated as fees for services. They shall be accompanied by a schedule showing the contribution and anticipated designation by the agency and shall be reported as restricted or appropriated as follows:
  - Restricted or Appropriated: Include funds which are either appropriated by the provider through formal board action or restricted by the donor. This includes interest from the contribution, when this interest is also restricted or appropriated and is held separate and not commingled with other funds.

- Not Restricted or Appropriated: Include donations which are not appropriated or designated by the provider through board action or restriction by the donor.
- Government Grants: Government grants should be explained on an accompanying schedule which sets forth the source of funding, the purpose and the period of the grant, and the program to which the grant pertains.

3. Schedule B

The purpose of Schedule B, Staff Numbers and Wages, is to report full-time equivalent numbers of staff and wages by job title.

Job Classification and Title: Enter the job titles in the space provided on the left. All personnel must be separated into the following job classifications:

- 2110 Administrative
- 2120 Professional
- 2130 Direct Client Care
- 2150 Clerical
- 2190 Other Staff Wages

Number of Staff: Enter the number of persons working full time or part time, and the total full-time equivalents (FTEs) for each job title. (For example, a person working half time has an FTE of 0.5.)

Gross Wages: Enter the gross wages for all full-time and part-time staff for each job title.

After the columns are completed, enter subtotals and total as indicated.

4. Schedule C

The purpose of Schedule C, Property and Equipment Depreciation and Related Party Property Cost, is to report information related to depreciable assets. Schedule C includes the original acquisition costs, capital improvements, and depreciation on buildings and equipment owned by the provider. If property is being leased from a related party, information regarding the lessor's costs must be submitted on Schedule C.

The totals reported on Schedule C are reported on Schedule D, account 4400. Ongoing expenses, such as maintenance and repairs for this property, are entered on Schedule D under subheadings for either 2800 (occupancy) or 4300 (repair expenses).

Note: Any property expenses related to providing room and board are not reimbursable under rule HCBS BI waiver program and should be excluded.

Calculate depreciation expense on a straight-line basis over the estimated useful life of the assets. Follow The Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association, for depreciation.

If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand alone functional capability may be considered on an item-by-item basis. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold. Stand alone office furniture (e.g., chairs, free standing desks) will be considered on an item-by-item basis.

Instructions are provided for each column in the section on Provider-Owned Equipment and Buildings:

Original Cost: Record the property and equipment at its original cost.

Depreciation Recorded Prior Years: Obtain this information by adding the depreciation accumulated from prior years less any disposals.

Method: Enter the method used by the agency in calculating its depreciation.

Annual % Rate: Enter the annual percentage rate used in calculating the depreciation.

Recorded Depreciation Expense: Enter the total amount of depreciation recorded on the agency's books.

Straight-Line Depreciation: Enter the amount of depreciation recorded on the property on a straight-line basis if the agency uses a method other than straight-line for its books.

Related Party Property Costs: A "related party" is defined as an organization related through control, form ownership, capital investment, directorship, or other means. Organizations are required to disclose their financial and statistical records to determine whether a related party relationship exists and to document the validity of costs.

If property is leased from a related party, the rent expense must be classified as a nonreimbursable cost on Schedule D, with the actual cost of the property substituted. A schedule of lessor's cost is included on Schedule C for purposes of identifying the actual cost incurred by the related party landlord.

5. Schedule D

The purpose of Schedule D, Expense Report, is to report total agency expenses and allocate those expenses to the various services provided by an agency. The allocation of costs per service includes all costs for your agency and should be consistent with the costs included on your general ledger.

The account numbers for expenditures are not intended to be all-inclusive in detailing expenses of a provider. The numbering system used on this schedule is not important, other than to have a basis of identifying object expenses in a manner that is uniform for reporting purposes.

HCBS uses several supplemental schedules to further clarify the application of these expenses.

a. Column Descriptions

Total Expense (Column 1): This column shows the total operating costs of the agency.

Fund-Raising Costs (Column 2): Use this column to show any adjustment to remove costs related to fund raising activities from allowable costs.

Other Nonreimbursable Costs (Column 3): Use this column to show any adjustments or reclassifications related to costs that are not reimbursed by the HCBS program. Examples of nonreimbursable costs include:

- Difference between book depreciation expense and that under the straight line method.
- Expenses not related to providing consumer care (personal expenses).
- Costs of consumer items provided that exceeds the $1570 limit per consumer. (See **Schedule D-1** for the consumer item limit calculation.)

You can use the nonreimbursable column to reclassify costs, such as:

- Moving agency vehicle depreciation to a direct cost line when the vehicle is used solely for the HCBS program.
- Moving food costs that are provided to the consumer at the provider site under the respite program.

Adjusted Costs (Column 4): This column shows costs that are allowable and allocable to HCBS programs, other programs, and indirect administrative costs. Indicate the balance of the expenses after deducting the items reflected in Columns 2 and 3 (fund-raising and nonreimbursable costs).

Direct Service Cost (Column 5 through 9 and 11 through 20, as needed): Use these columns for direct costs for each of the services or service sites provided, as defined below. Report direct costs by hourly service and by site.

In this accounting procedure, "direct" service expense include all direct personnel involved in a service. It includes the supervisor of that service or the appropriate prorated share of the supervisor's time. Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific **consumer** (e.g. hands-on, one-on-one consumer contact). Examples of nonbillable direct costs:

- Mileage costs for travel to and from the consumer site
- Time spent in staff meetings related to a particular consumer/HCBS service
- Time spent documenting services provided

Include in direct costs only the following specified line items related to the direct wages allocated:

- Line 2120: Professional Direct Care Staff
- Line 2130: Other Direct Staff
- Lines 2210-2290: Direct Staff Benefits
- Lines 2310-2350: Direct Staff Payroll Taxes
- Line 3210: Mileage and Auto Rental
- Line 3250: Agency Vehicle Expense
- Line 3290: Other Related Transportation
- Line 3520: Other
- Line 4320: Other Equipment Repair and Purchase

Show indirect costs in Column 10 **only**. Do not include indirect administrative costs in Columns 5-9.

Indirect Service Costs (Column 10): This column should include those service and administrative expenses that cannot be directly related to any specific service. Indirect costs after adjustments for fund-raising and nonreimbursable costs should be shown in column 10. Some examples of indirect administrative cost are:

- Staff development and training
- Receptionist position
- Office supplies
- Telephone
- Rent for administrative office
- Property or liability insurance

All indirect costs should be shown by line item in column 10 and then allocated in total to the various programs. Each agency is responsible for developing an acceptable method of distributing the indirect service costs to the various programs and supporting its rationale.

All line items may be used as appropriate to report indirect costs in column 10. All lines not specifically addressed under direct costs (above) should be used only for costs indirectly associated with the BI waiver program. There may be some cases where it is necessary to show indirect column 10 costs for those lines previously discussed as direct cost lines.

Indirect costs are limited to 20% of direct costs. See **Supplemental Schedule D-2** for calculation of the limit and any necessary adjustment.

b. Accounting Title Descriptions

This section includes additional instructions for reporting selected line items.

Line 2120: Professional Direct Staff. These positions provide assistance and support to direct support staff, may provide some direct service to the consumer in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

Calculate the salary expense related to this line item by multiplying the position's salary by the percentage of time spent in the specific program. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost.

Line 2130: Other Direct Staff. These positions provide direct support and assistance to the consumers. The wage amount is cash compensation and may also include noncash compensation of room and board, when applicable.

Direct support wages must reflect all direct support hours provided by agency personnel, including time spent on progress note, phone calls, and staffing meetings. Travel time to and from the service site should be accumulated separately from direct service time. Documentation should be available to support the travel time.

This item also includes contract services that provide direct support and assistance to consumers. The position is instead of, or in addition to, a direct support employee. Contract payments are made to persons who are not employees of the agency.

The total number of direct support and contracted hours corresponding to the direct wages must equal the direct support hours listed in the service plan.

Line 2290: Other Benefits. This item includes other benefits provided for employees, excluding travel and training costs.

Line 3210: Mileage and Auto Rental. This item includes staff mileage and expense. Mileage to and from the service site may be included as an indirect expense. Mileage cost reported is limited to the DHS employee reimbursement rate (currently 24¢ per mile).

Line 3250: Agency Vehicles Expense. Include expense for operation and maintenance of agency-owned vehicles used for the BI waiver program. Employee mileage to and from the service site in an agency vehicle may be included as a direct cost. Mileage cost reported is limited to the DHS employee reimbursement rate (currently 24¢ per mile).

Line 3290: Other Related Transportation. Include expense attributable to the actual transporting of the consumer (provided by staff, taxi, car pool, and bus fare) to allow the consumer to have access to community resources and opportunities. For supported community living, this item cannot pay for any mode of transportation that provides transportation to work. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1**.)

Line 3520: Other. Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of instructional activities identified in the consumer's service plan. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1**.)

Line 4320: Other Equipment Repair and Purchase. Include expense amounts for the modification or repair of the consumer's living unit. Expenses included may provide for reasonable accommodation of the behaviors of the consumer in rental units. For consumer-owned units, minor maintenance expenses may be included. Also, include household furnishings needed by the consumer. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1**.)

Line 3310: Staff Development and Training. Include all registration, tuition costs, travel, and living expenses incurred by the agency in sending staff members or volunteers to regional and national conferences or to workshops or institutes. Also show the travel and other costs incurred by an agency in bringing in an outside consultant to conduct a training institute in the agency for conferences or institutes in this item. All training should be classified as an indirect expense in column 10.

6. Supplemental Schedule D-1

The purpose of HCBS Supplemental Schedule D-1, Calculation of Consumer Cost Limits, is to calculate an average cost per consumer for consumer needs items and to determine the reasonableness of these items.

A consumer is eligible for $1570 of consumer items on an annual basis. The 12-month total of Schedule D lines 3290, Other Related Transportation; 3520, Other; and 4320, Other Equipment Repair and Purchase, cannot exceed $1570 per consumer. These costs need to be accumulated on an annual basis, with adjustments made for any excesses over the limit.

These expenses are defined as specific costs associated to the consumer. First seek all payment of these expenses from the consumer; second, from community resources; and third, from the HCBS program. The agency is responsible for tracking consumer costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per consumer adequately.

Complete a column for each living site or service. Carry over the consumer item costs from Schedule D. Divide the total costs by the number of unduplicated consumers at each living site for the current period. Compare the amount per consumer against the limitation of $1570 for each service per living site. Multiply any excess by the number of unduplicated consumers to obtain the total variance.

7. Supplemental Schedule D-2

The purpose of HCBS Supplemental Schedule D-2, Calculation of Indirect Cost Limits, is to calculate the indirect administrative cost limit of 20% of direct costs and to compare actual indirect costs allocated to HCBS services to that limit. This schedule compares actual indirect costs allocated to a living site or service against the limitation of indirect expense to 20% of direct costs.

Complete a column for each living site or service. Carry over the total expense by facility and service from the total expense line on Schedule D. This is the total expense, including the direct expense and the allocation of the indirect expense but before any income deductions. Carry over direct costs from the corresponding lines on Schedule D for each HCBS program and service. Calculate indirect costs by subtracting these direct expenses from the total.

Calculate the limit of 20% of direct costs using the subtotal of the direct costs lines. Compare this limitation against the calculated indirect expense. Carry forward any excess over the 20% limit to Supplemental Schedule D-3.

8. Supplemental Schedule D-3

The purpose of HCBS Supplemental Schedule D-3, *Reconciliation of Costs and Payments*, is to document cost per visit by service and to compare costs incurred to payments received. All prospective rates are subject to retrospective adjustment based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services.

File only one schedule for the HCBS program, showing all HCBS services. Carry to this schedule the direct costs plus indirect costs less any deduction on Schedule D. Costs may be combined into columns by service code. Also include any adjustment calculated on Schedule D-2. Then calculate total net costs of the other schedule adjustments per service code.

The next section of the schedule compares Medicaid's portion of the costs on the report to revenues billed from the Medicaid program. Use the lower of the adjusted costs per unit computed in the first part of schedule or the capped rate for the service multiplied by DHS units as the DHS cost to compare against revenues billed.

"Revenues billed" means payments received for a service category provided in the specified period and payments accrued, but expected to be received, for those services provided in the same period. These revenue figures come from provider records. Include only those payments received or expected to be received for the current period.

A balance due the Medicaid program may occur. Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the Bureau of Long-Term Care. The balance due should be remitted when the *Financial and Statistical Report* is filed. Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the Department will have this amount deducted from future payments.

9. Supplemental Schedule D-4

The purpose of HCBS Supplemental Schedule D-4, *Daily Rate Worksheet*, is to calculate the unit daily rates cost per living site. Costs reported by site should be consistent with those reported on Schedule, less any adjustment for the limit on indirect administrative costs.

If separate rates are needed for different consumers at a site, submit a Schedule D-4 for the site rate along with separate schedules for each consumer. (For the MR waiver, this could include consumers with different counties of legal settlement.) Indicate the number of consumers at the site and the site name.

Show direct costs by line item. Use actual costs for living sites not undergoing any significant change. Use projected costs if there are no representative historical costs available. Project the costs on an annual period. Complete spaces to show direct hours and miles. Show the lower of actual indirect costs or the 20% limit and add it to total direct costs. Then divide total costs by the units of service provided to calculate a unit cost.

For a living site that undergoes a significant change during the reporting period, this schedule may be submitted based on projected costs. A "significant" change occurs when a consumer's functioning level changes or you are unable to fill a vacancy within 30 days. Give a full explanation of the changes in the living site situation at the bottom of the schedule. Also give reasons for a request to exceed the unique rate maximum.

A living site rate may be adjusted no more than once every 3 months for the above reasons. The projected rate will not be inflated by the consumer price index (CPI).

10. Schedule E

The purpose of Schedule E, Comparative Balance Sheet, is to report the balance sheet of the provider as of the end of the reporting period.

Under "Assets, Liabilities, and Equity," the total assets must equal the total liabilities and equity.

Balance at End of Current Period: Enter the amount in effect for the last day of the reporting period.

Balance at End of Prior Period: Enter the amount in effect for the last day of the previous reporting period.

Under "Reconciliation of Equity or Fund Balance," the "add" and "deduct" entries should provide an explanation of any difference in the total equity of fund balance between the beginning and end of period.

Total Equity or Fund Balance Beginning of Period: This amount should be the same as the total liabilities and equity for the "balance at end of prior period." Add revenues from Schedule A and deduct expenses from Schedule D.

Total Equity or Fund Balance End of Period: This amount should be the same as the total liabilities and equity for the "balance at end of current period."

11. Schedule F

The purpose of Schedule F, Cost Allocation Procedures, is to report other supplemental information related to agency operations and accounting procedures. Complete Schedule F when your agency provides more than one service or service component.

Cost allocations are required for direct costs benefiting more than one service or service component and for the provider's indirect costs. "Direct" costs are those which are directly identifiable to services or components. "Indirect" costs, although they may benefit all services, generally are not readily identifiable with each service or service component. (See **Schedule D** for examples.)

The schedule provides questions about methods used in allocating expenses that benefit more than one service or service component. You should be able to support the basis used in allocating these costs. You may be required to obtain prior approval of the cost allocation plan from the regional office.

E. Rates Based Upon the Submitted Report

New providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period as reported in forms SS-1703-0 and 470-3449. After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as for an established provider.

Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation. The base period shall be the period covered by the first financial and statistical reports submitted to the Department after 1997 that include at least six months of actual, historical costs.

Reasonable and proper costs in the base period are inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

After establishment of the initial prospective rate for an established provider, the rate is adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the Department. The annual adjustment is equal to the increase in the consumer price index for all urban consumers for the preceding 12–month period ending June 30.

Hourly rates are based on the lesser of the actual cost per unit of the base period reported on Supplemental Schedule D-3 of 470-3449 or the unit maximum.

- An inflation factor will be added to the cost per unit of the previous reporting period not to allow the rate to exceed the unit maximum.
- No actual cost per unit rates will be set if the period reported is less than six months.
- No inflation factor will be added to projected rates.

Daily rates are based on the actual cost per unit of the base period reported on Schedule D-4 of form 470-3449 for each site, not to exceed the maximum unit rate.

- The Bureau of Long-Term Care may grant variations when cost-effective and in accordance with the service plan.
- No actual cost-per-unit rates will be set if the period reported is less than six months.
- An inflation factor is added to the cost per unit of the previous reporting period, not to exceed the unit maximum.

No rates are set for home and vehicle modification. This service is based upon one-time expenditures and not on a per-unit rate.

Projected rates will continue to be effective for providers with less than six months of actual cost data. Supported community living daily site rates that have been revised since the initial rate projection continue to be in effect if so noted on the submitted *Supplemental Schedule,* form 470-3449.

V. CLIENT PARTICIPATION

Consumers may be eligible to receive third-party vendor payments to cover the costs of some or all waiver services. This includes payments by Medicare, private health insurance, county government, or Veterans Administration aid and attendance. Generally, third-party vendor payments are paid directly to the provider. However, some third-party vendor payments are paid directly to the consumer.

Generally, a consumer eligible for physical disability waiver services under a FMAP-related, SSI-related, or 300% coverage group will not have client participation.

However, third-party medical payments that are intended to meet the costs of waiver services and which are paid directly to the consumer are counted for client participation.

The income maintenance worker determines the amount of the client participation and verifies third party liability, if any, and informs the consumer's service worker or Medicaid case manager.

The service worker will notify the provider of any client participation and whether there is third-party liability. The consumer is responsible to pay applicable client participation and administer third-party vendor payments. The provider is responsible to bill any third party or to collect from the consumer.

Providers can bill only for the difference between the client participation or third-party liability amounts and the cost for services. Bill waiver services showing third-party payments or client participation, even if no third-party or client participation payments are made.

Medicaid pays the balance of the cost of waiver services, up to the established limit, after third-party payment and client participation have been applied to the cost of services. If the consumer has an unused portion of client participation, the consumer retains the unused portion. Client participation is not carried over to the next month.

People who are eligible for waiver services under the Medicaid program, including those who currently have a health insurance policy, are encouraged to apply for the Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid recipients. The HIPP Medicaid program pays for private health insurance for Medicaid-eligible people when it is determined to be cost-effective. The program pays for the cost of premiums, coinsurance, and deductibles.

VI. PROCEDURE CODES AND MAXIMUM REIMBURSEMENT RATES

The following chart indicates the maximum possible reimbursement rate for all waiver services. The maximum service rates indicated may not reflect your actual costs. Therefore, if your actual costs do not meet the maximum rate identified, you must charge the general public the lesser rate. The lesser rate will be used to calculate the amount that you will bill to the fiscal agent for waiver services provided.

Each service must be billed in whole units.

You are responsible for communicating current service rates to the service worker or case manager who is responsible for writing a service plan for each individual receiving waiver services. Because the service plan authorizes waiver services, current service rates must be included.

HCPCS Code	Provider Category	Basis of Reimbursement	Upper Limit
W1002	Adult day care (day)	Fee schedule	V.A. contract rate or $41.09 for 4 to 8 hours
W1021	Adult day care (half day)	Fee schedule	V.A. contract rate or $20.54 for 1 to 4 hours
W1203	Adult day care (extended day)	Fee schedule	V.A. contract rate or $61.63 for 8 to 12 hours
W1265	Consumer-directed attendant care (agency provider)	Fee agreed upon by consumer and provider	$18.49 per hour not to exceed the daily rate of $106.82 (1-7 hours)
W1266	Consumer-directed attendant care (agency provider)	Fee agreed upon by consumer and provider	$106.82 per day (8-24 hours)

HCPCS Code	Provider Category	Basis of Reimbursement	Upper Limit
W1267	Consumer-directed attendant care (individual provider)	Fee agreed upon by consumer and provider	$12.33 per hour not to exceed the daily rate of $71.90 (1-7 hours)
W1268	Consumer-directed attendant care (individual provider)	Fee agreed upon by consumer and provider	$71.90 per day (8-24 hours)
W1037	Individual counseling, per 15 minutes	Fee schedule	$10.07 per unit
W1038	Group counseling, per hour	Fee schedule	$40.26 per hour
W1258	Home-delivered meals	Fee schedule	$7.19 per meal, maximum of 14 meals per week
T1021	Home health aide services, per visit	Retrospective cost-related	Maximum Medicare rate
W1040	Homemaker services, per hour	Fee schedule	$18.49 per hour
T1030 (RN) T1031 (LPN)	Nursing care, per visit	Agency's financial and statistical report and Medicare percentage rate per visit	$74.77 per visit
W2500	Respite-home health agency specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

HCPCS Code	Provider Category	Basis of Reimbursement	Upper Limit
W2501	Respite-home health agency basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
W2502	Respite-home health agency group respite	Retrospectively limited prospective rates	$12.24 per hour not to exceed $294 per day
W2503	Respite-home care agency and nonfacility specialized respite	Retrospectively limited prospective rates	$31.50 per hour not to exceed $294 per day
W2504	Respite-home care agency and nonfacility basic individual respite	Retrospectively limited prospective rates	$16.80 per hour not to exceed $294 per day
W2505	Respite-home care agency and nonfacility group respite	Retrospectively limited prospective rates	$12.24 per hour not to exceed $294 per day
W2506	Respite-facility care, hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for the skilled nursing facility level of care

HCPCS Code	Provider Category	Basis of Reimbursement	Upper Limit
W2507	Respite-facility care, nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility care
W2508	Respite-facility care, intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
W2509	Respite-facility care, foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
W2510	Respite-facility care, camps	Retrospectively limited prospective rates	$12.24 per hour not to exceed $294 per day
W2511	Respite-facility care, adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
W2512	Respite-facility care, child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem

I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

Submit billings for all AIDS/HIV waiver services to ACS on form 470-2486, *Claim for Targeted Medical Care*. You may obtain copies of this form from ACS at (515) 327-5120 or (800) 338-7909.

Bill ACS for each service rendered to each consumer (recipient) using applicable charges or the rate determined by the Bureau of Long-Term Care. The cost limits are presented in Chapter E, Section VI: **PROCEDURE CODES AND MAXIMUM REIMBURSEMENT RATES**. The maximum Medicaid rates are reviewed annually by the state legislature and, with the Governor's approval, are established effective July 1 for each state fiscal year.

To facilitate payment in a timely manner, submit claims to ACS on a monthly basis. To receive payment monthly, submit the claim for an entire month's service by the tenth of the month following the month of service. **Example:** A recipient received 24 hours of waiver service during the month of June. The claim for June's service should be submitted by the tenth day of July.

The following table contains information to aid in the completion of the *Claim for Targeted Medical Care*, form 470-2486. The table matches field numbers and names on the form, giving a brief description of what information is needed, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

Note: For Electronic Media Claim (EMC) submitters, refer to your EMC specifications for appropriate claim completion instructions.

Training in completing the claim form is available from ACS. Call ACS at the number listed above and request a field representative. The field representative will return your call a schedule a visit with you.

LOCATOR #/FIELD REQUIREMENTS		LOCATOR NAME	TARGETED MEDICAL CARE CLAIM FORM DESCRIPTION AND INSTRUCTIONS
1	**R**	**STATE ID**	Enter the consumer's Medicaid identification number found on the *Medical Assistance Eligibility Card*. This number consists of seven numeric characters and an ending alphabetic character. (For example, 1234567A)
1a	**R**	**CONSUMER ACCOUNT #**	Enter the account number assigned to the consumer by the provider of services. This field is limited to 10 alpha/numeric characters.
2	**R**	**CONSUMER'S NAME**	Enter the last name, first name, and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3	**R**	**TREATING PROVIDER NUMBER**	Enter the seven-digit Medicaid identification number of the treating provider.
4	**R**	**TREATING PROVIDER NAME**	Enter the provider name.
5	**R**	**TREATING PROVIDER ADDRESS**	Enter the provider address.
6	**R**	**PAY-TO PROVIDER NUMBER***	Enter the seven-digit Medicaid identification number of the billing provider if other than treating provider, i.e., physician = treating; institution = billing.
7		**PAY-TO PROVIDER NAME**	No entry required.
8	**C**	**OTHER INSURANCE: YES**	If the medical resource codes indicate there is other insurance coverage, or if you are aware of other coverage that will pay, check YES. Enter the amount the other insurance paid in box #14.
		OTHER INSURANCE: NO	Leave blank.
9	**C**	**OTHER INSURANCE DENIED: YES**	If the other insurance denied, check YES. Be sure to also check YES in box #8.

		OTHER INSURANCE DENIED: NO	Leave blank.
10		**SERVICES:**	
10A	**R**	**PROCEDURE CODE**	Enter the appropriate five-digit procedure code.
10B			Leave blank.
10C	**O**	**PROCEDURE DESCRIPTION**	Enter a complete description of the service performed.
10D	**R**	**PLACE OF SERVICE**	* Enter one of the two-digit codes as follows: 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room - hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance - land 42 Ambulance - air or water 51 Inpatient psychiatric facility 52 Psychiatric facility partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State of local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility

10E	**R**	**FIRST DATE OF SERVICE**	For the first month of service, enter the first date of service. In subsequent months, enter the first date of the calendar month for which the charge was incurred. The entry must be six digits (MM/DD/YY, for example 03/01/02). If there is client participation from the patient, only one calendar month can be billed per claim form. The county human services worker will inform you if you are to collect client participation from the patient.
10F	**R**	**LAST DATE OF SERVICE ***	Enter the last day of the calendar month that was entered in 10E. For the last month of service, enter the last date service was provided. The entry must be six digits (MM/DD/YY, for example 03/31/02). If there is client participation from the patient, only one calendar month can be billed on each claim form. The county human services worker will inform you if you are to collect client participation from the patient.
10G	**R**	**PROVIDER RATES ***	Enter the rate that you have been authorized in the Care Plan to bill Iowa Medicaid. This may be an hourly, daily, monthly, per visit, or per trip, depending on the service provided. Refer to Chapter E for unit rate descriptions.
10H	**R**	**UNITS ***	Enter the applicable number of units of service depending upon the procedure code you are billing. Bill only for services that you have provided. Round units for the entire month to the nearest whole number. Refer to Chapter E for procedure code descriptions.
10I		**TOTAL CHARGES ***	Multiply your provider rate (10G) times the number of units of service (10H). Enter the total charge for the month being billed.

11	**R**	**TOTAL CHARGE**	Enter the total change for all services being billed on this claim form.
12	**C**	**THIRD PARTY LIABILITY** *	Enter any insurance payments you have received for this claim. DO NOT enter Iowa Medicaid payments in this box.
13	**C**	**CLIENT PARTICIPATION** *	If you have been instructed by the county human services worker to collect a client participation amount from the recipient, enter it here. Otherwise, leave this box blank.
14	**R**	**BALANCE DUE**	Subtract the amounts in boxes 12 and 13 from the amount in box 11 and enter the amount due from the Medicaid program.
	R	**PROVIDER SIGNATURE**	Enter the signature of the authorized representative. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
	R	**DATE** *	Enter the date that the claim form is originally signed. If the claim form must be resubmitted, enter the original signature date.
	R	**CONSUMER/ GUARDIAN SIGNATURE**	For consumer-directed attendant care claims, the consumer (or the consumer's guardian, if applicable) must sign here.
	R	**DATE** *	Enter the date that the claim form is originally signed. If the claim form must be resubmitted, enter the original signature date.

B. Facsimile of Claim for Targeted Medical Services, Form 470-2486

(See the following pages.)

Iowa Department of Human Services

CLAIM FOR TARGETED MEDICAL CARE

(Please type. Accuracy is important.)

CHECK ONE:

❑ A = ILL & HANDICAPPED WAIVER ❑ B = AIDS WAIVER ❑ C = ELDERLY WAIVER ❑ D = MR WAIVER ❑ E = RESERVED
❑ F = BRAIN INJURY WAIVER ❑ G = CASE MGT ❑ H = RESERVED ❑ I = RESERVED ❑ J = RESERVED
❑ P = PHYSICAL DISABILITY WAIVER

(A) CONSUMER INFORMATION:

STATE ID:	1	CONSUMER ACCT #:	1a
CONSUMER'S NAME:	2 LAST	FIRST	MI

(B) PROVIDER INFORMATION:

TREATING PROVIDER NUMBER / NAME:	3	/	4
TREATING PROVIDER ADDRESS: (STREET, CITY, STATE, ZIP)	5		
PAY - TO PROVIDER NUMBER / NAME:	6	/	7

8 **OTHER INSURANCE:** ❑ YES ❑ NO 9 **OTHER INSURANCE DENIED:** ❑ YES ❑ NO

10 **(C) SERVICES:**

A. PROC CODE	B.	C. PROCEDURE DESCRIPTION	D. * PLACE OF SVC	E. FIRST DATE MM/DD/YY	F. LAST DATE MM/DD/YY	G. PROVIDER RATES	H. UNITS	I. TOTAL CHARGES
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			
				__/__/__	__/__/__			

* PLACE OF SERVICE (REFER TO CODES ON BACK)

I certify that the statements on the back apply to this bill and are made a part of it.

PROVIDER SIGNATURE DATE

For consumer-directed attendant care claims only:

CONSUMER/GUARDIAN SIGNATURE DATE

TOTAL CHARGE:	11
THIRD PARTY LIABILITY:	12
CLIENT PARTICIPATION:	13
BALANCE DUE:	14

MEDICAID PAYMENTS

(PROVIDER CERTIFICATION)

I hereby agree:

- To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.
- To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.
- To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.
- To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

- The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.
- The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.
- The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

11 Office
12 Home
21 Inpatient hospital
22 Outpatient hospital
23 ER room hospital
24 Ambulatory surgical center
31 Skilled nursing facility
32 Nursing facility
33 Custodial care facility
34 Hospice
51 Inpatient psychiatric facility
53 Community mental health center
54 Intermediate care facility/MR
55 Residential substance abuse treatment facility
56 Residential psychiatric treatment facility
61 Comp inpatient rehab facility
62 Comp outpatient rehab facility
71 Public health clinic
99 Other

C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- Do not attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  ACS State Healthcare
  P.O. Box 14422
  Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

Pay-to-Provider Number

Recipient Name _____

Recipient State ID Number

Date of Service ____/____/_____

Type of Document

_____

_____

_____

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.

DENIED represents all processed claims for which no reimbursement is made.

SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the *Medicaid Provider Application* at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See following pages.)

IAMC8000-R001 (CP-O-12)
AS OF 05/19/97

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/12/97

1.

R E M I T T A N C E A D V I C E

4.

TO: [redacted] 2. R.A. NO.: 0000022 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [redacted] PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: WAIVER						* * * CLAIM STATUS: PAID							
ORIGINAL CLAIMS:			7.			8.	9.	10.	11.				14.
5. [redacted]	[redacted]	6. [redacted]	4-96326-00-131-0055-00		18.	9359.15	0.00	9359.15	0.00	12.	13.		000 000
		01	08/01/95	W1300	31	1519.31	0.00	1519.31	0.00	[redacted]		B	000 000
		02	09/01/95	W1300	30	1470.30	0.00	1470.30	0.00	[redacted]		B	000 000
	15.	03 16.	10/01/95	W1300 17.	31	1862.79	0.00	1862.79	0.00	[redacted]		B	000 000
		04	11/01/95	W1300	30	1802.70	0.00	1802.70	0.00	[redacted]		B	000 000
		05	12/01/95	W1300	31	1862.79	0.00	1862.79	0.00	[redacted]		B	000 000
		06	01/01/96	W1300	14	841.26	0.00	841.26	0.00	[redacted]		B	900 000
[redacted]	[redacted]	[redacted]	4-96340-00-102-0034-00			5197.71	0.00	0.00	0.00				000 000
		01	09/09/96	W1300	22	2157.54	0.00	0.00	0.00	[redacted]		K	000 000
		02	10/01/96	W1300	31	3040.17	0.00	0.00	0.00	[redacted]		K	000 000

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	14,556.86		9,359.15
PAID ADJUSTMENT CLAIMS: 19.	NUMBER OF CLAIMS	0	0.00		0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	0.00		0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	0.00		0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	0.00		0.00
AMOUNT OF CHECK:					9,359.15

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 10 was intentionally left blank.

C. Remittance Statement Field Description

1. Pay-to provider name as specified on the *Medicaid Provider Enrollment Application*.
2. *Remittance Advice* number.
3. Date claim paid.
4. Medicaid (Title XIX) pay-to provider number.
5. Recipient last and first name.
6. Recipient Medicaid ID number.
7. Transaction control number assigned by fiscal agent to each claim. Please use this number when making inquiries about claims.
8. Total charges submitted by provider.
9. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
10. Total amount paid by Medicaid for this claim.
11. Total amount of recipient copayment deducted from this claim.
12. Medical record number as assigned by provider/Medicaid ID number of provider performing services.

13. Allowed charge source code.

B	Billed charge	**F**	Fee schedule
K	Denied	**N**	Provider charge rate
P	Group therapy	**Q**	EPSDT total screen over 17 years
R	EPSDT total under 18 years	**S**	EPSDT partial over 17 years
T	EPSDT partial under 18 years	**U**	Gynecology fee
V	Obstetrics fee	**W**	Child fee

14. Explanation of benefits code indicates the reason for claim denial. Refer to explanation at end of the remittance for each EOB code in the *Remittance Advice*.

15. Line item number.

16. The first date of service for the procedure billed.

17. The procedure code for the service billed.

18. The number of units of service rendered.

19. Remittance totals (found at the end of the *Remittance Advice*).

- Number of paid original claims/amount billed/amount allowed and paid.
- Number of paid adjusted claims/amount billed/amount allowed and paid.
- Number of denied original claims/amount billed/amount allowed and paid.
- Number of denied adjusted claims/amount billed/amount allowed and paid.
- Number of pended claims (in process)/amount billed/amount allowed.
- Amount of check.

20. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire remittance *advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. 17-DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FISCAL AGENT RESPONSE

INQUIRY B

1. 17–DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FISCAL AGENT RESPONSE

Provider Signature/Date:	**MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422**	**ACS Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR ACS USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

Page 16 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ CLAIM ADJUSTMENT	❑ CLAIM CREDIT	❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN																	

2. Pay-to Provider #:	4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:	Provider/Representative Signature:
	Date:

FISCAL AGENT USE ONLY: REMARKS/STATUS

Return All Requests To:

ACS
PO Box 14422
Des Moines, IA 50306-3422

March 26, 1996

For Human Services Use Only

General Letter No. 8-A-AP(II)-589

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 96-1

Subject: ***HCBS AIDS/HIV Waiver Manual***, Contents, pages 4 and 5, revised; and Chapter E, *Coverage and Limitations*, pages 1 through 9, revised; and pages 10, 11, and 12, new.

Chapter E is revised to include new policy as follows:

- Home-delivered meals are now an allowable service.
- The upper rate limit for hourly respite is changed to $12.00 from $9.27. Hourly respite may be provided by HCBS MR respite providers or homemakers employed by home care or home health aide providers.
- The unit of service for nursing care is changed to a visit from 15 minutes. The unit of services for home health aide service is changed to a visit from an hour.

Date Effective

March 1, 1996

Material Superseded

Remove from the ***HCBS AIDS/HIV Waiver Manual***, and destroy Contents, page 4, dated March 1, 1995, and page 5, dated June 1, 1994; and Chapter E, pages 1, 2, 4, and 6, dated March 1, 1995; pages 3, 5, and 9, dated November 1, 1995; and pages 7 and 8, dated June 1, 1994.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-57
Employees' Manual, Title 8
Medicaid Appendix

April 17, 1998

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS AIDS/HIV Waiver Manual***, Table of Contents, pages 4 and 5, revised; Chapter E, *Coverage and Limitations*, pages 1 through 12, revised; pages 13 through 20, new; and Chapter F, *Billing and Payment*, pages 1 through 12, revised.

Chapter E is revised to include new policy as follows:

- Consumer-directed attendant care is now an allowable service as of August 1, 1997.
- Adult day care is now an allowable service as of August 1, 1997.

Chapter F is revised to transmit updated billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove from ***HCBS AIDS/HIV Waiver Manual*** and destroy:

Page	Date
Contents (pages 4 and 5)	March 1, 1996
Chapter E	
1-12	March 1, 1996
Chapter F	
1-2	June 1, 1994
3-4	5/92
5-10	June 1, 1994
11	Undated
12	04/30/93
13-14	05/21/93
15-16	June 1, 1994

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

For Human Services use only:

General Letter No. 8-AP-122
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

August 6, 1999

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS AIDS/HIV Waiver Manual***, Chapter E, *Coverage and Limitations*, pages 1, 2, 5, 6, 9, 10, 13, 17, and 18, revised; and Chapter F, *Billing and Payment*, pages 4, 5, and 6, revised; and page 4a, new.

Summary

References to "case plan" and "individual comprehensive plan" have been changed to "service plan" to conform to certification standards and other waivers.

The *Claim for Targeted Medical Care* is revised to add a field for the consumer signature. The instructions are revised to require this signature on claims for consumer-directed attendant care.

Date Effective

May 1, 1999

Material Superseded

Remove the following pages from ***HCBS AIDS/HIV Waiver Manual*** and destroy them:

Page	Date
Chapter E	
1, 2, 5, 6, 9, 10, 13, 17, 18	April 1, 1998
Chapter F	
4	April 1, 1998
5, 6	4/98

Additional Information

Supplies of the previous version of the claim form can be used up for services other than consumer-directed attendant care. Order supplies of the revised form from Consultec in the usual manner.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-135
Employees' Manual, Title 8
Medicaid Appendix

March 1, 2000

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS AIDS/HIV Waiver Manual***, Chapter E, *Coverage and Limitations*, pages 18 through 20, revised.

Summary

The Iowa Legislature appropriated increases in reimbursement rates to several Medicaid provider types effective July 1, 1999. This manual release updates procedure codes that received a 2% increase to the rates or rate caps.

Any changes in rates must be ordered and approved in the consumers' service plans before billing. For services that have rates established through the financial and statistical cost reporting process, rates cannot be changed until cost reporting is complete for FY 1999.

Date Effective

July 1, 1999

Material Superseded

Remove the following pages from ***HCBS AIDS/HIV Waiver Manual*** and destroy them:

Page	Date
Chapter E	
18	May 1, 1999
19, 20	April 1, 1998

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-152
Employees' Manual, Title 8
Medicaid Appendix

September 15, 2000

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 00-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS AIDS/HIV Waiver Manual***, Table of Contents (page 5), revised; Chapter E, *Coverage and Limitations*, page 20, revised; and Chapter F, *Billing and Payment*, page 4, revised, and pages 13 through 17, new.

Summary

The changes to Chapter E reflect out-of-home respite rate changes paralleling facility respite rate changes.

Any changes in rates must be ordered and approved in the consumers' service plans before billing.

The changes to Chapter F revise claim completion instructions for client participation to match narrative instructions and add two forms to be used to resolve problems with submitted claims.

Date Effective

February 1, 2000 for Chapter E revisions

April 1, 2000 for Chapter F revisions

Material Superseded

Remove the following pages from the ***HCBS AIDS/HIV Waiver Manual*** and destroy them.

Page	Date
Table of Contents (page 5)	April 1, 1998
Chapter E	
20	July 1, 1999
Chapter F	
4	May 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

For Human Services use only:

General Letter No. 8-AP-170
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

July 13, 2001

HCBS AIDS/HIV WAIVER SERVICES MANUAL TRANSMITTAL NO. 01-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS AIDS/HIV WAIVER SERVICES MANUAL***, Table of Contents (pages 4 and 5), revised; Contents (page 6), new; Chapter E, *Coverage and Limitations*, pages 1 through 20, revised; and pages 21 through 88, new; and Chapter F, *Billing and Payment*, pages 1 and 4a, revised.

Summary

This letter transmits changes to the HCBS AIDS/HIV waiver effective July 1, 2000; May 1, 2001; and July 1, 2001.

The following changes were effective July 1, 2000:

- Respite services are expanded by adding medical respite, expanding potential providers, and increasing rates for all providers. In addition, criteria are added to require safety procedures during the provision of respite care.

  Respite services provided by home health agencies, home care agencies, and other nonfacility providers are divided into specialized respite, group respite, and basic individual respite, with separate rates of payment.

  - "Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.
  - "Group respite" is respite provided on a staff-to-consumer ratio of less than one to one and "basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

  This manual release identifies new procedure codes and unit reimbursement upper limits. Provider agencies are responsible for communicating rate changes to consumers' service workers and case managers. Changes in rates must be ordered and approved in the consumers' service plans before billing.

- The reimbursement rates for counseling, homemaker, nursing, home-delivered meals, adult day care, and consumer-directed attendant care providers increased by 0.7 percent. HCBS waiver home health providers are paid the maximum Medicare rate.

This manual release updates procedure codes that received a 0.7% increase to the rates or rate caps. Provider agencies are responsible for communicating rate changes to consumers' service workers and case managers. Changes in rates must be ordered and approved in the consumers' service plans before billing.

- A *Financial and Statistical Report for Purchase of Service Contracts*, form 470-3449, is required to be filed annually to reconcile respite services for the following types of respite providers:
  - Home health agencies providing group respite.
  - Non-facility providers of specialized, basic individual and group respite.
  - Camps.
  - Home care agencies providing specialized, basic individual and group respite.

The following changes were effective May 1, 2001:

- Adult day service providers enrolled to provide consumer-directed attendant care services are no longer required to submit a detailed cost report.
- Persons with durable power of attorney for medical care are added to the list of people who can agree to consumer-directed attendant care services on behalf of a consumer.
- Policy governing consumer-directed attendant care services is revised to allow the assistance of consumers with job-related tasks at the direction of the Health Care Financing Administration.
- The terms "individual comprehensive plan" and "case plan" are replaced by "service plan" throughout the manual.

Effective July 1, 2001, form 470-2917, *Medicaid HCBS Waiver Provider Application*, is revised to include new covered services for the mental retardation waiver.

Dates Effective

July 1, 2000, and May 1, 2001 and July 1, 2001

Material Superseded

Remove the following pages from the ***HCBS AIDS/HIV WAIVER SERVICES MANUAL***, and destroy them:

Page	Date
Table of Contents	
4	April 1, 1998
5	April 1, 2000
Chapter E	
1, 2	May 1, 1999
3, 4	April 1, 1998

5, 6	May 1, 1999
7, 8	April 1, 1998
9, 10	May 1, 1999
11, 12	April 1, 1998
13	May 1, 1999
14-16	April 1, 1998
17	May 1, 1999
18, 19	July 1, 1999
20	February 1, 2000
Chapter F	
1	April 1, 1998
4a	May 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-211
Employees' Manual, Title 8
Medicaid Appendix

May 5, 2003

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HCBS AIDS/HIV WAIVER MANUAL***, Contents (page 5), revised; Chapter E, *Coverage and Limitations*, pages 2 through 12, 13, 29 through 36, 43, and 80, revised; page 12a, new, and Chapter F, *Billing and Payment*, pages 1, 4, 4a, 5, 6, 7, 13, 15, and 17, revised.

This manual is revised to:

- Update form 470-2917, *Medicaid HCBS Waiver Provider Application*, which has been revised to change its layout and structure and to provide more clarity in completion. The instructions are revised to comply with the new layout.
- Update form 470-2486, *Claim for Targeted Medical Care*, which has been revised to include the signature of the provider for consumer-directed attendant care and a column that identifies the specific rate for any Medicaid service. This revision will assist the provider in computing accurate total charges.
- Change references from "Consultec" to "ACS" and from "Division of Medical Services" to "Bureau of Long-Term Care."

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from ***HCBS AIDS/HIV WAIVER MANUAL*** and destroy them:

Page	Date
Table of Contents (p. 5)	July 1, 2000
Chapter E	
2	July 1, 2000
3	May 1, 2001
4	July 1, 2000
5-12 (470-2917)	7/01
13	July 1, 2000
29-36 (470-3372)	9/00
43, 80	July 1, 2000

Chapter F

1	July 1, 2000
4	April 1, 2000
4a	July 1, 2000
5, 6 (470-2486)	2/99
7	April 1, 1998
13	April 1, 2000
15 (470-3744)	4/00
17 (470-0040)	4/00

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-226
Employees' Manual, Title 8
Medicaid Appendix

August 14, 2003

HCBS AIDS/HIV WAIVER MANUAL TRANSMITTAL NO. 03-2

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HCBS AIDS/HIV WAIVER MANUAL***, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, pages 70, 71, and 86, revised; Chapter F, *Billing and Payment*, pages 15, and 17, revised; and pages 6a, and 6b, new.

Summary

Chapter E has been revised to:

- Provider Manual for the ***HCBS AIDS/HIV WAIVER MANUAL*** has been revised to update the policy for depreciation for providers under the waiver who complete a cost report. The cost threshold will now be $5000 instead of $500. If a depreciable asset has at the time of it acquisition an estimated useful life of at least two years and a historical cost of at least $5000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated uniform national standards for health information. Consequently, Iowa Medicaid initiated a review of all local "W" HCPCS codes that are unique to Iowa Medicaid. These local codes are being replaced by HCPCS Level II codes. The codes for home health aide and nursing are being changed for the waivers.

Chapter F has been revised to add instructions for form 470-3969, *Claim Attachment Control*, used to submit paper attachments for an electronic claim.

Date Effective

Immediately

Material Superseded

Remove the following pages from ***HCBS AIDS/HIV WAIVER MANUAL*** and destroy them:

Page	Date
Contents (page 5)	May 1, 2003
Chapter E	
70, 71	July 1, 2000
86	May 1, 2001
Chapter F	
15 (470-3744)	10/02
17 (470-0040)	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

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PO Box 14422
Des Moines, IA 50306-3422

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